MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09338

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
MARYLAND
LENGTH OF STAY (in this place): 35 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
STREET ADDRESS (If rural, give location): 309 Garland Avenue

3. NAME OF DECEASED (Type or Print): (First) Ernestine (Middle) (none) (Last) Albertson

4. DATE OF DEATH: (Month) Sept. (Day) 25 (Year) 1950

5. SEX: Fe

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2-1-96

9. AGE last birthday: 54 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Potomac Conference

11. BIRTHPLACE (State or foreign country): Montreal, Canada

12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME: Robert Morris

14. MOTHER'S MAIDEN NAME: Clara Ayers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lymphosarcoma, general involving the retroperitoneal area and retro mediastinal area

200.1

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

46 hrs

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-20, 1950, to 9-25, 1950, that I last saw the deceased alive on 9/24, 1950, and that death occurred at 12 01 A.m., from the causes and on the date stated above.

SIGNATURE: A.R. Coyne (Degree or title) MD ADDRESS: Takoma Park Md DATE SIGNED: 9/25/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Sept 27/50 NAME OF CEMETERY OR CREMATORY: George Wash. Cem. LOCATION (City, town, or county) (State): Rockville Md

DATE REC'D BY LOCAL REG. 9/26/50

REGISTRAR'S SIGNATURE: J. Milton Dodd

24. FUNERAL DIRECTOR: J. Arthur Waller ADDRESS: 254 Carroll St Takoma Park D.C.

23/6/92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
SEP 28 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09339

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH: COUNTY Montgomery County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.
STREET ADDRESS (If rural, give location) 523 Buchanan St. N.W. ✓

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) (Last) Applestein

4. DATE OF DEATH (Month) 9 (Day) 17 (Year) 1950

5. SEX Male
6. COLOR OR RACE Hebrew
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 11-11-1890
9. AGE last birthday 59 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY ?
11. BIRTHPLACE (State or foreign country) Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Applestein
14. MOTHER'S MAIDEN NAME Sarah Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Washington Sanitarium + Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Embolism.

602X Antecedent cause(s) (b) ① Ureteral lithotomy.

134a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ② Bronchoscopy for Atelectasis.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 9-11-50.
19b. MAJOR FINDINGS OF OPERATION Large Calculus - ureteropelvic junction - l.
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-7, 1950, to 9-17, 1950, that I last saw the deceased alive on 9-17, 1950 and that death occurred at 10:05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul E. Cavet M.D. ADDRESS Wash. D.C. DATE SIGNED 9-17-50

23. BURIAL CREMATION REMOVAL (Specify) DATE 9/19/50 NAME OF CEMETERY OR CREMATORY Eversovetdrat Cem. LOCATION (City, town, or county) Washington D.C. (State)

DATE REC'D BY LOCAL REG. 9/19/50 REGISTRAR'S SIGNATURE J. Wilson Dodd
24. FUNERAL DIRECTOR B Danzansky & Son ADDRESS 3001 14 St Wash. D.C. NW

27860

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
SEP 21 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09340

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10109 Grant Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 10109 Grant Ave.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) W. (Last) Armstrong

4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Nov. 6, 1875

9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired. Bureau of Engraving

10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.

11. BIRTHPLACE (State or foreign country) Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jos. H. Annand

14. MOTHER'S MAIDEN NAME Alice Mackey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Mr. T. K. Armstrong, 10109 Grant Ave. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.0	Immediate cause	(a) Cerebral Hemorrhage	2 days
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart Disease	—
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 19, 1950 to Sept 9, 1950, that I last saw the deceased alive on Sept. 9, 1950, and that death occurred at 1:05 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Marion Bankhead MD ADDRESS 9601 Sutton Place S. S. Md. DATE SIGNED 9/9/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 9/11/50

NAME OF CEMETERY OR CREMATORY Congressional Cemetery

LOCATION (City, town, or county) (State) Washington, D. C.

DATE REC'D BY LOCAL REG. 9-11-50

REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR Warner E. Pumphrey ADDRESS 8434 Georgia Ave. Silver Spring, Md.

XVX 98

RECEIVED
SEP 14 1950
BUREAU OF

Evidence for change in #11 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FILE NO. 6 128 NOV 1 1950 FOR MEDICAL EXAMINERS

09341

Reg. Dist. No. 2-17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooke Rd
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sandy Springs

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooke Rd.
STREET ADDRESS (If rural, give location): Sandy Spring

3. NAME OF DECEASED (Type or Print): (First) Joyce (Middle) Wendy (Last) Awkward

4. DATE OF DEATH: (Month) Sept (Day) 11 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: aug 2, 1950

9. AGE Last birthday: 6 weeks — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland Phila, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Robert awkard

14. MOTHER'S MAIDEN NAME: Frances Ward.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Frances awkward

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

921.0 **Immediate cause** (a) Asphyxia due to vomitus (accidental) — 5 min.

1952 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ **CAUSE OF DEATH.**

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: home (CITY OR TOWN): Sandy Spring (COUNTY): Mont (STATE): Md

TIME OF INJURY (Month) 9 (Day) 11 (Year) 50 (Hour) 11 A m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?: strangulation by food

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) **ADDRESS**: Frank J. Broccard M.D. Gaithersburg Md — **DATE SIGNED**: 9-11-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE THEREOF**: 9/12/50 — **NAME OF CEMETERY OR CREMATORY**: Sandy Spring — **LOCATION (City, town, or county) (State)**: Sandy Spring, Md

DATE REC'D BY LOCAL REG.: 9-12-50 — **REGISTRAR'S SIGNATURE**: Gertrude B Fawley — **24. FUNERAL DIRECTOR**: Robert L. Snowden — **ADDRESS**: Rockville, Md.

9V-8-02-0-99V99V

RECEIVED
SEP 14 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09342

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA SUBURBAN HOSPITAL · LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8600 OLD GEORGETOWN ROAD	STREET ADDRESS (If rural, give location) 525 Anderson Ave.

3. NAME OF DECEASED (Type or Print) (First) GORDON (Middle) WELLINGTON (Last) BAILEY				4. DATE OF DEATH (Month) Sept. (Day) 16, (Year) 1950	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11 Dec. 1890	9. AGE last birthday 59 yrs.	If under 1 year Months 9 Days 5 · If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Machinist Instrument Maker	10b. KIND OF BUSINESS OR INDUSTRY US Pub. Health		11. BIRTHPLACE (State or foreign country) Nokesville, Virginia	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wellington G. Bailey			14. MOTHER'S MAIDEN NAME Sarah Sanford		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. 577-10-4107		17. INFORMANT AND ADDRESS Mrs L.S. Bailey 525 Anderson Ave. Rockville, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
331x Immediate cause	(a) MASSIVE CEREBRAL HEMORRHAGE	13 HOURS
Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ARTERIAL HYPERTENSION	5 YEARS
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/15, 1950, to 9/17, 1950, that I last saw the deceased alive on 9/16, 1950, and that death occurred at 12:40 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gordon S. Rasenberger		Rockville Md.	9/16/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 19 Sept. 1950	NAME OF CEMETERY OR CREMATORY Rockville Union	LOCATION (City, town, or county) (State) Rockville, Maryland
DATE REC'D BY LOCAL REG. 9-18-50	REGISTRAR'S SIGNATURE Helen Kurvack	24. FUNERAL DIRECTOR Robert H. Humphrey	ADDRESS Bethesda, Md.

32698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
SEP 21 1950
BUREAU V. S

Barnes, Mrs. Mar

MARYLAND STATE DEPARTMENT OF HEALTH

09343

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 410 Potomac Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 410 Potomac Avenue

3. NAME OF DECEASED (Type or Print): (First) Mrs. (Middle) Grace (Last) Taylor Barnes

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Nov. 4, 1878

9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Taylor

14. MOTHER'S MAIDEN NAME: Laura Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Viola Mae Frymyer, 410 Potomac Ave. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Acute Coronary Infarction,

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 25 1950, to Sept 21, 1950, that I last saw the deceased alive on Sept 6, 1950, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Dean H. Harding MD | 113 Carroll St N.W. Wash., D.C. | 9-22-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Sept. 23, 1950 | NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery | LOCATION (City, town, or county) (State): Gaithersburg, Maryland

DATE REC'D BY LOCAL REG. 9/25/50 | REGISTRAR'S SIGNATURE Frances Potter | 24. FUNERAL DIRECTOR ADDRESS: Warner E. Pumphrey, Silver Spring, Maryland

RECEIVED
SEP 27 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09344

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
LENGTH OF STAY in this place: 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Virginia — COUNTY: Fairfax
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Falls Church
STREET ADDRESS (If rural, give location): 720 Broad Street ✓

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Francis (Last) BARTHES

4. DATE OF DEATH: (Month) September (Day) 3 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Aug. 28, 1950

9. AGE last birthday: 00 yrs. If under 1 year: Months 00 Days 05 If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: August A. BARTHES

14. MOTHER'S MAIDEN NAME: Cecilia GARRIGA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT AND ADDRESS: Mother: Cecilia G. BARTHES

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776K
159

Immediate cause (a) Prematurity

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 28, 1950 to Sept. 3, 1950, that I last saw the deceased alive on Sept. 3, 1950, and that death occurred at 12:15A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

A. GEDAROVICH, LTJG, MC, USN U.S. NAVAL HOSPITAL September 5, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Removal

DATE THEREOF: Sept. 5, 1950

NAME OF CEMETERY OR CREMATORY:

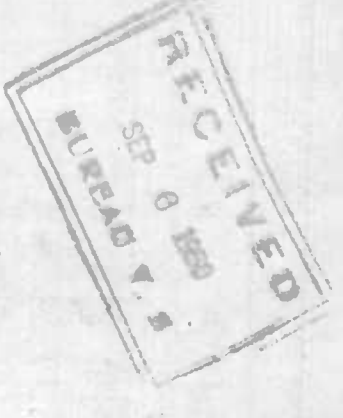
LOCATION (City, town, or county) (State): Pensacola, Florida

DATE REC'D BY LOCAL REG.: Sept. 5, 1950

REGISTRAR'S SIGNATURE: Neal Whittington

24. FUNERAL DIRECTOR: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Maryland. ADDRESS

2-0-8-28-0 34-3-28-1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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09345

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. #1, Silver Spring, Md. LENGTH OF STAY (In this place) 16yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gayfields - (Home)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D., #1, Silver Spring,
STREET ADDRESS (If rural, give location) Gayfields - (Home)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Ruth Ethelyn Baughman

4. DATE OF DEATH (Month) (Day) (Year) Sept. 19 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 22, 1903
9. AGE last birthday 47 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Racine, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Melvin Tidyman
14. MOTHER'S MAIDEN NAME Mattie Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mr. Wilbur N. Baughman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

198.1 Immediate cause (a) Epithelioma of left inguinal gland

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with general metastasis

55e (c)

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. no attending physician since 1948

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 9-20-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 22, 1950
NAME OF CEMETERY OR CREMATORY St. John's Cemetery
LOCATION (City, town, or county) Olney, Maryland (State)
DATE REC'D BY LOCAL REG. 9/22/50
REGISTRAR'S SIGNATURE Frances Potter
24. FUNERAL DIRECTOR Warner E Pumphrey ADDRESS Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 26 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09346

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery Co. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park.; LENGTH OF STAY (in this place) 18 Months; HOSPITAL OR INSTITUTION OR STREET ADDRESS 818 Davis Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Mont; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park; STREET ADDRESS (If rural, give location) 818 Davis Avenue

3. NAME OF DECEASED (Type or Print): (First) Lottie (Middle) P (Last) Belknap.

4. DATE OF DEATH: (Month) Sept. (Day) 17 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Aug. 12, 1877

9. AGE last birthday: 73 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): East Barnard, Vermont

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: James Monroe Belknap

14. MOTHER'S MAIDEN NAME: Jennie Beach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Geo. Davis 818 Davis Ave. Tak. Pk. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Cardiac Failure — Interval Between Onset and Death: Terminal

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Skin - Metastatic Breast — 5 years

191X 53

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12/4/49 Biopsy

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Skin - Metastatic

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1950, to Sept 17, 1950, that I last saw the deceased alive on Sept 16, 1950, and that death occurred at 1 pm. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Robert A Hare M.D. ADDRESS: Takoma Park, Md. DATE SIGNED: 9/18/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: Sept 19, 1950 NAME OF CEMETERY OR CREMATORY: Geo Wash. Mem. Cemetery LOCATION (City, town, or county): Hyattsville (State): Md.

DATE REC'D BY LOCAL REG. 9/18/50 REGISTRAR'S SIGNATURE: J A Weller Deputy

24. FUNERAL DIRECTOR: J. Arthur Walters ADDRESS: 254 Carroll St. NW DC

RECEIVED
SEP 21 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09347

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montg Co, MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg; LENGTH OF STAY (in this place) 35yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg; STREET ADDRESS (If rural, give location) 8 Walker Ave

3. NAME OF DECEASED (Type or Print): (First) Garrison (Middle) Warfield (Last) Bell

4. DATE OF DEATH: (Month) 9 (Day) 14 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Apr 11/1891

9. AGE last birthday: 59 yrs. If under 1 year: Months 5 Days 3 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Executive

10b. KIND OF BUSINESS OR INDUSTRY: Farming Product

11. BIRTHPLACE (State or foreign country): Montg Co. Md,

12. CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: William D. Bell

14. MOTHER'S MAIDEN NAME: Della V. Warfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Family Records, Janet W. Bell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: sudden death.

4201

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

940

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Bouchart M.D. (Degree or title) ADDRESS Gaithersburg Md DATE SIGNED 9-14-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 9/16/50 | NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery | LOCATION (City, town, or county) Gaithersburg Md, (State)

DATE REC'D BY LOCAL REG. Sept. 14, 1950 | REGISTRAR'S SIGNATURE Almeda L. Cooke

24. FUNERAL DIRECTOR ADDRESS Ernest C, Gartner. Gaithersburg/Md,

27852

RECEIVED
SEP 18 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09348

CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 35 Sycamore Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New York; COUNTY Westchester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hastings-on-Hudson; STREET ADDRESS (If rural, give location) 65 Summit Dr.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) PORTER (Last) BELL

4. DATE OF DEATH: (Month) 9 (Day) 1 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 10-8-1858

9. AGE last birthday: 91 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Dayton, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Porter

14. MOTHER'S MAIDEN NAME: Ruth Meguel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: James L. Bell, 3916-13th St. N.W. - D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypostatic Pneumonia — Interval Between Onset and Death: 24 hrs

420.1 Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial Failure with coronary Sclerosis ?

(c) Nephritis - Generalized Atherosclerosis ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 20, 1950, to August 19, 1950, that I last saw the deceased alive on Aug 9, 1950, and that death occurred at 11:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Philip E. Jones M.D. 904 Ellsworth Drive Silver Spring, Md 9-1-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 9-2-50 — NAME OF CEMETERY OR CREMATORY: Evandale Cemetery — LOCATION (City, town, or county) (State): Somers, N.Y.

DATE REC'D BY LOCAL REG. 9-2-50

REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR ADDRESS: A.H. Hines Co, Washington, D.C.

RECEIVED
SEP 6 1950
BUREAU V. S

09349

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (Rural) LENGTH OF STAY (in this place) 2das
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 660 Morton Place, NorthEast

3. NAME OF DECEASED (Type or Print) (First) Daniford (Middle) Franklin (Last) BLAKE
4. DATE OF DEATH (Month) Sept (Day) 3 (Year) 1950

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 12-11-01
9. AGE last birthday 49 yrs. If under 1 year Months 8 Days 23 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pulman Porter
10b. KIND OF BUSINESS OR INDUSTRY - - - -
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Gill G. BLAKE
14. MOTHER'S MAIDEN NAME Catherine BARBER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI
16. SOCIAL SECURITY NO. ---------
17. INFORMANT AND ADDRESS Bro: William M. Blake-Same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive Heart Failure

443 × Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardiovascular Disease

93d (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Sept 3, 1950, that I last saw the deceased alive on Sept 3, 1950, and that death occurred at 6:25 Am., from the causes and on the date stated above.

SIGNATURE R O Peckinpaugh (Degree or title) ADDRESS DATE SIGNED
R. O. PECKINPAUGH, LTJG MC USN U.S. NAVAL HOSPITAL BETHESDA MD 9-4-50

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 9-4-50
NAME OF CEMETERY OR CREMATORY Rock Hill
LOCATION (City, town, or county) (State) Rock Hill, S. C.

DATE REC'D BY LOCAL REG. 9-4-50
REGISTRAR'S SIGNATURE Edith Whittington
24. FUNERAL DIRECTOR ADDRESS Frazier Funeral Home 389 R.I. Ave NW Washington, D. C. C.B.C.

75047

RECEIVED
SEP 8 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09350

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place): 13
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 740 Silver Spring Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 740 Silver Spring Avenue

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Ziegler (Last) Bocek

4. DATE OF DEATH: (Month) Sept. (Day) 15 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 24, 1878

9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Vienna, Austria

12. CITIZEN OF WHAT COUNTRY?: Austria

13. FATHER'S NAME: Leopold Ziegler

14. MOTHER'S MAIDEN NAME: Elizabeth Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mr. Leon Leopold Bocek, 740 Silver Spring, Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Massive Collapse Right Lung	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Osteoporosis Spinal Column	5 years
	(c) Subclinical Diabetes Mellitus	6 mos.

260X
733X
61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1949, to Sept., 1950, that I last saw the deceased alive on 9-15, 1950, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): L. B. Snow M.D. — ADDRESS: Silver Spring, Md. — DATE SIGNED: 9-16-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 18, 1950 — NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery — LOCATION (City, town, or county) (State): Washington, D. C.

DATE REC'D BY LOCAL REG.: 9/18/50 — REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR — ADDRESS: Warner E. Pumphrey, 8434 Georgia Ave. Silver Spring, Md.

RECEIVED
SEP 20 1950
BUREAU OF

Evidence for addition of #8 & 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

09351

FILM No. G 128 OCT 19 1950

Reg. Dist. No. 211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Monrovia (rural)
LENGTH OF STAY (In this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Brownsville

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Mont
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Monrovia (rural)
STREET ADDRESS (If rural, give location): Brownsville

3. NAME OF DECEASED (Type or Print): (First) Millard (Middle) D. (Last) Burdette

4. DATE OF DEATH: (Month) Sept (Day) 29 (Year) 1950

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: about 1885

9. AGE last birthday: 65 yrs. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: [illegible]

11. BIRTHPLACE (State or foreign country): md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John F. Burdette

14. MOTHER'S MAIDEN NAME: Flonnie Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: 215 22 0169

17. INFORMANT: Millard Burdette Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: Found dead in bed

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
94a
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): Frank J. Broschart M.D. ADDRESS: Gaithersburg md DATE SIGNED: 9-29-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Oct 2. 1950
NAME OF CEMETERY OR CREMATORY: Damascus Md
LOCATION (City, town, or county) (State): Montgomery Co Md

DATE REC'D BY LOCAL REG.: Oct. 2. 1950.
REGISTRAR'S SIGNATURE: Della W. Burdette
24. FUNERAL DIRECTOR: Roy W. Barber
ADDRESS: Poolesville Md

RECEIVED
OCT 4 1950
BUREAU V. S.

09352

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Alice (Last) Carroll
4. DATE OF DEATH (Month) Sept. (Day) 21, (Year) 1950
5. SEX Female
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 8-22-50
9. AGE last birthday yrs. If under 1 Months. 1 year Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bethesda, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Stephen Aloysius Carroll
14. MOTHER'S MAIDEN NAME Estelle Wims
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

274X Immediate cause (a) Adrenal insufficiency

Antecedent cause(s)

65b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 1:30 P. m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Suburban Hospital, Bethesda, Md DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) DATE 9/24/50 NAME OF CEMETERY OR CREMATORY Rocky Hill LOCATION (City, town, or county) Clarksburg, Md (State)

DATE REC'D BY LOCAL REG. 9-24-50 REGISTRAR'S SIGNATURE Helen Kurvack
24. FUNERAL DIRECTOR Robert L. Snowden, Rockville, Md ADDRESS

2-0-8-22-0-29-6-40-6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 26 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09353

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Cove, Md.
LENGTH OF STAY (in this place): Since ~~Jan.~~ Nov. 1950
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4917 Keokuk Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Cove, Md.
STREET ADDRESS (If rural, give location): 4917 Keokuk Street

3. NAME OF DECEASED (Type or Print): (First) Ben (Middle) M. (Last) Chapman

4. DATE OF DEATH: (Month) September (Day) 2, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 6-12-1885

9. AGE last birthday: 65 yrs. If under 1 year: Months 2 If under 24 hrs.: Hours 20 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Government Office-War Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Worked For Gov't.

11. BIRTHPLACE (State or foreign country): Pomaria, South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES K. CHAPMAN

14. MOTHER'S MAIDEN NAME: MARY CHAPMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mrs. Margie Chapman-4917 Keokuk Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Obstruction, intestinal	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinomatosis	2 mos.
154X 46d	(c) Carcinoma, rectum primary	6 mos.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: April 17, 1950

19b. MAJOR FINDINGS OF OPERATION: Carcinoma rectum.

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 3, 1950, to Sept 2, 1950, that I last saw the deceased alive on Aug 31, 1950, and that death occurred at 3:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): A W Smith MD

ADDRESS: 4601 16th St. NW Wash. D.C.

DATE SIGNED: 9/2/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 9-5-1950

NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

LOCATION (City, town, or county) (State): Bladensburg Rd. Md.

DATE REC'D BY LOCAL REG. 9-2-50

REGISTRAR'S SIGNATURE: Helen Kinsella

24. FUNERAL DIRECTOR: Martin W. Hysong ADDRESS: Martin W. Hysong Co. 1300 N. Street, N.W. Wash DC

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RECEIVED
SEP 5 1950
BUREAU V. S

09354

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs, Md. LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore,
HOSPITAL OR INSTITUTION OR STREET ADDRESS 207 Melbourne Rd.	STREET ADDRESS (If rural, give location) 2810 E. Baltimore Street ✓

3. NAME OF DECEASED (Type or Print): (First) VIRGINIA (Middle) FRANCES (Last) CHESNEY

4. DATE OF DEATH (Month) (Day) (Year): Sept. 28, 50 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Mar. 4, 1870

9. AGE last birthday: 80 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis G. Ingram

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: 6910 Bellona Avenue Mr. B. Clarence Chesney

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CARDIAC ARREST	15 min.
434.1 Antecedent cause(s)	(b) CHRONIC CONGESTIVE HEART FAILURE	5 yrs.
93e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 28 1950, to Sept. 28, 1950, that I last saw the deceased alive on Sept. 28, 1950, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE L. B. Snow M.D. (Degree or title) ADDRESS Silver Spring, Maryland DATE SIGNED 9/28/50

23. BURIAL, CREMATION REMOVAL (Specify): burial DATE 10/2/50 NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 9/29/50 REGISTRAR'S SIGNATURE H.W. Hedrick DM

24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. BALTO. 13, MD. ADDRESS Nellie L. Hill

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Coroner (Dr. Brochait) notified
and will approve

09355

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 43 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Quantico
STREET ADDRESS (If rural, give location) Box 243

3. NAME OF DECEASED (Type or Print) (First) Olive (Middle) Watson (Last) COLEMAN
4. DATE OF DEATH (Month) Sept (Day) 30 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Jan 7, 1895
9. AGE last birthday 55 yrs. If under 1 year Months 8 Days 23 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Samuel WATSON
14. MOTHER'S MAIDEN NAME Amanda Bryan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Quantico, Va. Daughter: Ruth C. Bogert Box 243

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broncho pneumonia	2 days
171X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) widespread metastases	30 days
48a	(c) Carcinoma of Cervix	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Carcinoma of Cervix
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 18, 1950 to Sept 30, 1950, that I last saw the deceased alive on Sept 30, 1950, and that death occurred at 12:13 Am., from the causes and on the date stated above.

SIGNATURE S. L. Arje (Degree or title) CDR (MC) USN ADDRESS U. S. Naval Hospital DATE SIGNED September 30 '50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 4, 1950
NAME OF CEMETERY OR CREMATORY Arlington National
LOCATION (City, town, or county) Arlington (State) Virginia
DATE REC'D BY LOCAL REG. Sept 30 '50
REGISTRAR'S SIGNATURE Edith Whittington
24. FUNERAL DIRECTOR R. W. Hall ADDRESS Hall Funeral Home, Occoquan, Va.

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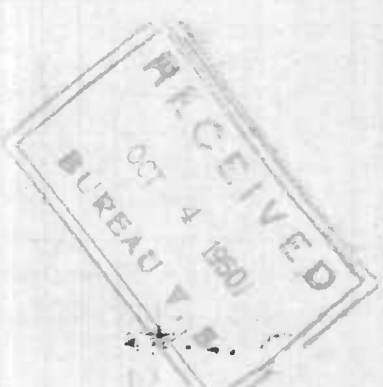
VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
OCT 4 1960
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

09356

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mrs. Whitleys Rest Home 10204 Greenock Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 2500 Que St., N.W.

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) (Last) Cox
4. DATE OF DEATH: (Month) 9 (Day) 7 (Year) 19 50

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: 2/2/64
9. AGE last birthday: 86 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert McCoy
14. MOTHER'S MAIDEN NAME: Elizabeth Hardway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs. Blaine Sturgis 2500 Que St., N.W.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Acute Congestive failure — 1 week

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Mooth) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 45, to Sept 7, 1950, that I last saw the deceased alive on Sept 6, 1950, and that death occurred at 9 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

James J. Whisman MD — 3100 R St N.W. D.C. — 9-7-50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 9/8/50 — NAME OF CEMETERY OR CREMATORY: Sligonville Cemetery Lawrenceville Va. — LOCATION (City, town, or county) (State): Robinson, Illinois

DATE REC'D BY LOCAL REG. 9/6/50 — REGISTRAR'S SIGNATURE: Frances Potter — 24. FUNERAL DIRECTOR — ADDRESS: The H. Wise Co. 2901-14th St. N.W. Wash. D.C.

VS. A15

RECEIVED
SEP 11 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09357

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Suburban Hospital
COUNTY Montgomery County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda,
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda 14, Maryland
STREET ADDRESS (If rural, give location) 5927 Wilson Lane

3. NAME OF DECEASED (Type or Print) (First) Douglas (Middle) E (Last) Cummings

4. DATE OF DEATH (Month) 9 (Day) 17 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov 7, 1911
9. AGE last birthday 39 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant
10b. KIND OF BUSINESS OR INDUSTRY Selfemployed
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Herbert. Cummings
14. MOTHER'S MAIDEN NAME Annie Franklin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. 265-14-4201
17. INFORMANT AND ADDRESS Dr. Rosaland E Barbach Cummings FLA.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Sub arachnoid hemorrhage	76 hours.
330X Antecedent cause(s)		
830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mild arterial hypertension	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) 9 (Day) 13 (Year) 50 (Hour) 11:30 p.m. m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-14, 1950, to 9-17, 1950, that I last saw the deceased alive on 9-16, 1950, and that death occurred at 3:15A m., on 9-17-50 from the causes and on the date stated above.

SIGNATURE Alfred E. Norton (Degree or title) M.D. ADDRESS 546 Maple Ridge Road Bethesda Md. DATE SIGNED 9-17-50

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE Sept 17, 1950
NAME OF CEMETERY OR CREMATORY Forrest Lawn Cem. Via L.T. Christian
LOCATION (City, town, or county) (State) Richmond Virginia

DATE REC'D BY LOCAL REG. 9-17-50
REGISTRAR'S SIGNATURE Helen Kurvach
24. FUNERAL DIRECTOR Robert A Pumphrey Pen. D.L.C.
ADDRESS 4557 Wisconsin Ave Bethesda 14 Md.

21099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 21 1950
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

09359

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: TAKOMA PARK
LENGTH OF STAY (in this place): 1YR 3 MO
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 100 BALTIMORE AVE

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: WASHINGTON — COUNTY: D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WASH. D.C.
STREET ADDRESS (If rural, give location): 121 WEBSTER ST N.W.

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) H. (Last) DAVIDSON

4. DATE OF DEATH: (Month) Sept. (Day) 10 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: NOV. 9 1868

9. AGE last birthday: 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REALTOR

10b. KIND OF BUSINESS OR INDUSTRY: REAL ESTATE

11. BIRTHPLACE (State or foreign country): LONDON, OHIO

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: JANE TAGGART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: DOROTHY JACKSON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Acute Myocardial Failure	1 day
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)	Coronary Arteriosclerosis	10 yrs.
794a (c)	Generalized Arteriosclerosis	20 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1950, to Sept. 10, 1950, that I last saw the deceased alive on Sept. 10, 1950, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jas. van Kinsbergen, M.D. — ADDRESS: 29 Grant Cir. NW. Wash, D.C. — DATE SIGNED: 9/10/50

23. BURIAL CREMATION REMOVAL (Specify) — DATE THEREOF: Sept-11-1950 — NAME OF CEMETERY OR CREMATORY: Kirkwood Cem — LOCATION (City, town, or county) (State): London, Madison Co Ohio

DATE REC'D BY LOCAL REG. 9/10/50 — REGISTRAR'S SIGNATURE: J. Wilson Dodd

24. FUNERAL DIRECTOR: THE S. H. HINES CO. — ADDRESS: 2901 14TH ST NW, WASH. D.C.

27681

RECEIVED
SEP 13 1950
BUREAU V. S

09358

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

mtCB

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: 4918 Albemarle St. N.W. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LENGTH OF STAY (in this place): 1½ yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wash. D.C.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Glenn Manor 2515 Holman Ave. S.S. Md.	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Genevieve	(Middle) A.	(Last) Davis	4. DATE OF DEATH (Month) Sept. (Day) 23 (Year) 1950
5. SEX: Fe	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: Oct. 11, 1882	9. AGE last birthday: 67 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Wash. D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Ghio		14. MOTHER'S MAIDEN NAME: Unk.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Norman Davis - 4918 Albemarle St. N.W.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypostatic Pneumonia	6 days
260X Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes mellitus with acidosis	?
61	(c) Congestive Heart Failure	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized Arteriosclerosis	?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to Sept 18, 1950, that I last saw the deceased alive on Sept 18, 1950, and that death occurred at 1:15 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Philip E. Jones	M.D.	904 Ellsworth Drive Silver Spring Md.	9/23/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 9-23-50	NAME OF CEMETERY OR CREMATORY: Wash DC	LOCATION (City, town, or county) (State): Wash DC
DATE REC'D BY LOCAL REG. 9/25/50	REGISTRAR'S SIGNATURE: Frances Potter	24. FUNERAL DIRECTOR: W. R. Huntsman	ADDRESS: 5732 Fa. Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 27 1960
BUREAU V. S

09360

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- Montrose
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Waverley Sanatorium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
STREET ADDRESS (If rural, give location) 405 Cumberland Ave.

3. NAME OF DECEASED (Type or Print) (First) MAXWELL (Middle) W. (Last) DAY

4. DATE OF DEATH (Month) Sept. (Day) 25, (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 20March 1865
9. AGE last birthday 85 yrs. If under 1 year Months 6 Days 5 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Electrical Engineer
10b. KIND OF BUSINESS OR INDUSTRY Self Employed
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME S. Mills Day
14. MOTHER'S MAIDEN NAME Lucy Maxwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Irving M. Day Sr. 405 Cumberland Ave. Chevy Chase, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
450	Immediate cause	(a) Toxemia + Hypertension Crisis	2 Days
97	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arteriosclerosis	Years
		(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1945, to Sept 1950, that I last saw the deceased alive on Sept 24, 1950, and that death occurred at 335 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Leo I. Donovan MD ADDRESS 8016 Georgetown Road Bethesda Maryland DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit
DATE THEREOF 27Sept.1950
NAME OF CEMETERY OR CREMATORY Vale Cemetery
LOCATION (City, town, or county) Schenectady, (State) New York

DATE REC'D BY LOCAL REG. 9-26-50
REGISTRAR'S SIGNATURE Helen Kurva Ck
24. FUNERAL DIRECTOR Robert A. Humphrey ADDRESS Bethesda, Md.

V 1899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 30 1950
BUREAU V. S

09361

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

M

I

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural — LENGTH OF STAY (in this place): 1 mo 3 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: District of Columbia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 416 L Street, NW ✓

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Rudolph (Last) DUNSTON
4. DATE OF DEATH (Month) (Day) (Year): September 3, 1950

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Mar. 3, 1916
9. AGE last birthday: 34 yrs. — If under 1 year: Months 06 Days 00 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manservant
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John DUNSTON
14. MOTHER'S MAIDEN NAME: Rose (Surname unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES ✓ (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT AND ADDRESS: Friend; Cleo GLOVER

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lung abscess	1 Mo
422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Drosher pneumonia	1 Month
93d	(c) Ischaemia Myocardium with Cardiac Decompensation	2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 30 1950, to Sept. 3, 1950 that I last saw the deceased alive on Sept. 3, 1950, and that death occurred at 2:40 P m., from the causes and on the date stated above.

SIGNATURE: J. T. JONES, Jr. (Degree or title) LTJG, MC, USN — ADDRESS: U.S. NAVAL HOSPITAL — DATE SIGNED: September 5, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Sept. 8, 1950
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Sept. 5, 1950
REGISTRAR'S SIGNATURE: Edith Whittington
24. FUNERAL DIRECTOR — ADDRESS: W. E. Jarvis Funeral Home, 1432 U Street, NW, Washington, D.C.

W. Ernest Jarvis Co. (Mr. C.J.)

52086

RECEIVED
SEP 6 1960
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09362

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 6600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linden
STREET ADDRESS (If rural, give location) Brookville Road.

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) (Last) Fields

4. DATE OF DEATH: (Month) Sept. (Day) 24 (Year) 1950

5. SEX: male

6. COLOR OR RACE: black

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Sept. 24/50

9. AGE last birthday: Newborn yrs. If under 1 year: Months | Days: 11 hrs. | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Suburban Hospital

12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: Julius Thomas Scott

14. MOTHER'S MAIDEN NAME: Mary Jean Fields

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Suburban Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Patent Ductus Arteriosus — 13 hrs 7 min

760.0 Antecedent cause(s)

160a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Atelectasis

(c) 4th Ventricle hemorrhage. —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): 9-24 ? m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? Unknown - Delivery spontaneous.

22. I hereby certify that I attended the deceased from 9-27, 1950, to 9-27, 1950, that I last saw the deceased alive on 9-24, 1950, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE: H.H. Mitchell (Degree or title) M.D. ADDRESS 8055-13th St. — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE: 9-26-50 | NAME OF CEMETERY OR CREMATORY: Suburban Hospital | LOCATION (City, town, or county): Bethesda (State): Md.

DATE REC'D BY LOCAL REG. 9-26-50 | REGISTRAR'S SIGNATURE: Helen Kurvath

24. FUNERAL DIRECTOR: Amelia Manry Supt. ADDRESS

2-0-9-24-0-37-7-37-5

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 3 1950
BUREAU V. S

09363

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring R.F.D. LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Smithtown

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring (rural)
STREET ADDRESS (If rural give location) Smithtown

3. NAME OF DECEASED (Type or Print) (First) John (Middle) R. (Last) Fitzgerald

4. DATE OF DEATH (Month) Sept (Day) 30 (Year) 1950

5. SEX male

6. COLOR OR RACE col

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Jan 18, 1896

9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Farm helper

11. BIRTHPLACE (State or foreign country) Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT Lillie Fitzgerald

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
919.9 Immediate cause	(a) Hemorrhage due to gun shot	sudden
184 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) wound in left chest thru heart	death
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Silver Spring (COUNTY) Montgomery (STATE) Md.

TIME OF INJURY (Month) Sept (Day) 30 (Year) 1950 (Hour) 6 A m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Shot while squirrel hunting

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Brosehart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 9-30-50

23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF 10/4/50 NAME OF CEMETERY OR CREMATORY Good Hope LOCATION (City, town, or county) Colesville, Md. (State)

DATE REC'D BY LOCAL REG. 10/5/50 REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR R. L. Snowden, Rockville, Md. ADDRESS

866 VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

I

RECEIVED
OCT 10 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09364

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural; LENGTH OF STAY (in this place) 18 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Dist. of Columbia; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington; STREET ADDRESS (If rural, give location) 3614 Connecticutt Ave., N.W. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Marie	Labat	FLUBACHER	September 11, 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	Sept. 12, 1883	66 yrs.	11	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	- - - - -	France	US (N)

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
J. P. LABAT	Marie L. MOROT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO - - - - -	- - - - - - -	Son: Raymond H. FLUBACHER

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
204.0 Immediate cause (a) Leukemia, Chronic lymphogenous	10-11 yrs.
7da Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug. 23, 1950, to Sept. 11, 1950, that I last saw the deceased alive on Sept. 11, 1950, and that death occurred at 7:20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
E. M. SPAULDING, CDR, MC, USN	U.S. NAVAL HOSPITAL,	Sept. 12, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 15, 1950	Cedar Hill Cemetery	Washington, D. C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 12, 1950	Edith Whittington	S. H. Hines,	2901 14th St., NW, Washington, D.C.

RECEIVED
SEP 14 1950
BUREAU V. R

09365

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 218

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithersburg
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R. F. D.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithersburg, Md
STREET ADDRESS (If rural, give location): R. F. D.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) E (Last) Frazier
4. DATE OF DEATH: (Month) Sept. (Day) 10, (Year) 1950
5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Oct 1888
9. AGE last birthday: 61 yrs. — If under 1 year: Months 11, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: B+O-R.R.
11. BIRTHPLACE (State or foreign country): Gaithersburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Cy Frazier
14. MOTHER'S MAIDEN NAME: Mary Nolan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 705, 10, 2018
17. INFORMANT: Isaac Thompson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary occlusion — suddenly

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Emil J. Bauersfeld M.D. — (Degree or title) Dep. Med. Ex. Mon. Co. — ADDRESS: Bethesda, Md — DATE SIGNED: 9/12/50.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 9/13/1950
NAME OF CEMETERY OR CREMATORY: St Rose
LOCATION (City, town, or county) (State): Cloppers, Md

DATE REC'D BY LOCAL REG.: Sept. 12, 1950
REGISTRAR'S SIGNATURE: Alfreda G. Cooke
24. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville Md.

98847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 14 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09366

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery Co. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colesville; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Jolliffe's Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New York COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flushing; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) LAWRENCE (Middle) F (Last) GOULD

4. DATE OF DEATH: (Month) Sept. (Day) 1st (Year) 1950

5. SEX Mal MALE

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH Oct 3 1881

9. AGE last birthday 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Engineer

11. BIRTHPLACE (State or foreign country) Providence R. I.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Amos Gould

14. MOTHER'S MAIDEN NAME Lotta Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 097-03-0161

17. INFORMANT AND ADDRESS Mrs L H Gould wife 1975 Linkum Knows Flushing #208

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral-Vascular Accident — Interval Between Onset and Death: 3½ days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senile Arteriosclerosis — 3 years

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15, 1950 to 9-1, 1950, that I last saw the deceased alive on 9-30, 1950, and that death occurred at 1 4 m., from the causes and on the date stated above.

SIGNATURE Chas. O Gere (Degree or title) M.D. ADDRESS 8007 Sligo Ave. Silver Spring Md. DATE SIGNED 9-1-50

23. BURIAL, CREMATION REMOVAL (Specify) Removal

DATE THEREOF Sept. 1st 1950

NAME OF CEMETERY OR CREMATORY Columbia Gardens

LOCATION (City, town, or county) Arlington (State) Va.

DATE REC'D BY LOCAL REG. 9/1/50

REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR C. P. Cluss ADDRESS

37299

RECEIVED
SEP 5 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09367

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 3 mo 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia — COUNTY Alexandria
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alexandria
STREET ADDRESS (If rural, give location) 716 Gibbon Street ✓

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) William (Last) GRAY

4. DATE OF DEATH (Month) (Day) (Year): September 12, 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Feb. 13, 1923

9. AGE last birthday: 27 yrs. If under 1 year: Months 06 Days 29 If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not employed

10b. KIND OF BUSINESS OR INDUSTRY: — — — — — — —

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Clarence GRAY

14. MOTHER'S MAIDEN NAME: Elsie WASHINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. — — — — — —

17. INFORMANT AND ADDRESS: Wife: Irene GRAY

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	48 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hodgkin's Disease	14 mos.
	(c)	

20/X
44-

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 6, 1950, to Sept. 12, 1950, that I last saw the deceased alive on Sept. 12, 1950, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
J.R. SHANAHAN, LTJG, MC, USN	U.S. NAVAL HOSPITAL	Sept. 13, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 18, 1950	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Sept. 13, 1950	Edith Whittington	J.T. Rhines & Co., 901 3rd St., SW, Washington, D.C.

J. E. M

RECEIVED
SEP 15 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09368

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE North Carolina; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cherry Point ✓
STREET ADDRESS (If rural, give location) U.S. Marine Corps Air Station

3. NAME OF DECEASED (Type or Print): (First) (none); (Middle) (none); (Last) GREBE

4. DATE OF DEATH: (Month) (Day) (Year) September 19, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 18, 1950

9. AGE last birthday: 00 yrs. If under 1 year: Months 00, Days 01; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Camp Lejeune, N. C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Arthur J. GREBE

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: - - - - -

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

770.5 Immediate cause (a) Erythroblastosis Foetalis.

159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 19, 1950, to Sept. 19, 1950 that I last saw the deceased alive on Sept. 19, 1950, and that death occurred at 3:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

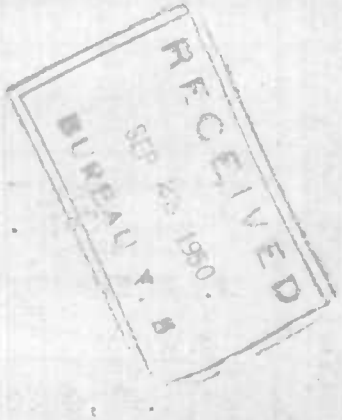
Allen Gedarovich
A. GEDAROVICH, LTJG, MC, USN U.S. NAVAL HOSPITAL, September 22, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Sept 25, 1950
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Sept. 22, 1950
REGISTRAR'S SIGNATURE: Edith Worthington

24. FUNERAL DIRECTOR ADDRESS: R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Maryland.

9V9180994V994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SEP 29 1980
BUREAU

09369

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 10½ days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C.
STREET ADDRESS (If rural, give location) 2540 - 14th St. N.W. ✓

3. NAME OF DECEASED (Type or Print) (First) Jonas (Middle) Willard (Last) Greene Jr.

4. DATE OF DEATH (Month) 9 (Day) 14 (Year) 1950

5. SEX Male
6. COLOR OR RACE Wh.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 7-4-80
9. AGE last birthday 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired D.C. Policeman
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Manassas, VA.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jonas Willard Greene Sr.
14. MOTHER'S MAIDEN NAME Elizabeth Hazen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS 2540 - 14th St. N.W. Pts. wife - Washington D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause	(a) Arteriosclerotic Heart Dis. Congestive failure	1 year Prostate
Antecedent cause(s)	Chronic nephritis c renal decompensation	2-3 wh
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Uremia	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) 0
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) 0 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/11, 1950, to 9/14, 1950, that I last saw the deceased alive on 8/13, 1950, and that death occurred at 2:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Chas. H. Wolohm, 500 Underwood St. N.W. Wash. D.C. 9/14/50

23. BURIAL CREMATION REMOVAL (Specify) DATE 9/17/50 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) Manassas (State) Va.

DATE REC'D BY LOCAL REG. 9/14/50 REGISTRAR'S SIGNATURE J. Wilson Dodd
24. FUNERAL DIRECTOR S. H. Hines Co. 2901-14th St. N.W. Wash. D.C. ADDRESS

60497

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SEP 15 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09370

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY Northhampton
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Temperanceville
STREET ADDRESS (If rural, give location) Church Street ✓

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) Ann (Last) HENINGER

4. DATE OF DEATH (Month) (Day) (Year): September 27, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 20, 1950

9. AGE last birthday: 00 yrs. If under 1 year: Months 00 Days 07 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William B. HENINGER

14. MOTHER'S MAIDEN NAME: Lucille TUCKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - -

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS: Lucille T. HENINGER (Mother)

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 **Immediate cause** (a) Atelectasis — Interval Between Onset and Death:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

159 (b) Sclerema Neonatorum

(c) Prematurity

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 20 1950, to Sept 27, 1950 that I last saw the deceased alive on Sept 27, 1950, and that death occurred at 1:10 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): A. Gedarovich
A. GEDAROVICH, LTJG, MC, USN — ADDRESS: U.S. NAVAL HOSPITAL — DATE SIGNED: September 28, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct. 2, 1950 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Sept. 28, 1950 — REGISTRAR'S SIGNATURE: Edith Worthington

24. FUNERAL DIRECTOR ADDRESS: R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.

94 9200 994 99V

RECEIVED
SEP 29 1930
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

09371

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
LENGTH OF STAY (In this place): 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 34 Sycamore Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: TAKOMA PARK
STREET ADDRESS (If rural, give location): 34 SYCAMORE AVE.,

3. NAME OF DECEASED (Type or Print): (First) ELD. (Middle) WALTER KONRAD WILHELM (Last) ISING

4. DATE OF DEATH: (Month) SEPT. (Day) 23 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	MARRIED	MAR. 30, 1881	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MINISTER (retired)	SDA.	DANZIG, GERMANY	U.S.A.

13. FATHER'S NAME: Julius Ising

14. MOTHER'S MAIDEN NAME: BODKE.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	NONE	MRS. FRIDA ISING, 34 SYCAMORE AVE, TAKOMA PARK, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
177X Immediate cause	(a) Cancer of liver	1 year
51b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cancer of prostate	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Sept 23, 1950, that I last saw the deceased alive on Sept 21, 1950, and that death occurred at 10:25 A.m., from the causes and on the date stated above.

SIGNATURE: John N. Andrewsmd. (Degree or title) ADDRESS: 9601 Colesville Rd Silver Spring Md DATE SIGNED: SEP 23 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	SEPT 26 1950	GEO. WASH CEMETERY INC.	RIGGS Rd. (Prince Geo Co) HYATTSVILLE MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/24/50	J. Milton Dodd	J. ARTHUR WALTERS,	254 CARROLL ST. N.W., WA 8944 TAKOMA PARK, 12, D.C.

RECEIVED
SEP 26 1950
BUREAU V. S.

09372

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural give location) 706 Maple Ave.

3. NAME OF DECEASED (Type or Print) (First) ANNE (Middle) N. (Last) JEFFERS

4. DATE OF DEATH (Month) 9 (Day) 29 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 25 Jan. 1885
9. AGE last birthday 65 yrs. If under 1 year Months 8 Days 5 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier
10b. KIND OF BUSINESS OR INDUSTRY Gov't. Services /Inc.
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Norton
14. MOTHER'S MAIDEN NAME Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 057-12-9149
17. INFORMANT Norton L. Jeffers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

174X Immediate cause (a) Carcinoma of Uterus with

Antecedent cause(s)

48b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Abdominal metastases

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 26, 1950, to Sept 29, 1950, that I last saw the deceased alive on Sept 29, 1950, and that death occurred at 9:50 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Bernard A. Fitzgerald MD. ADDRESS 802 Malcolm Drive S.S. Md DATE SIGNED 10/2/50

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE 2 Oct. 1950
NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
LOCATION (City, town, or couuty) (State) Suitland, Maryland

DATE REC'D BY LOCAL REG. 102-50
REGISTRAR'S SIGNATURE Helen Kurvach
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Md. 21098

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 5 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09373

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 6808 Exeter Road

3. NAME OF DECEASED (Type or Print): (First) Jasper (Middle) Loring (Last) JENKINS

4. DATE OF DEATH: (Month) (Day) (Year) September 22, 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Sept. 18, 1890

9. AGE last birthday: 60 yrs.
If under 1 year: Months 00 Days 05
If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Marine

10b. KIND OF BUSINESS OR INDUSTRY: Armed Forces

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William JENKINS

14. MOTHER'S MAIDEN NAME: Sarah CARPENTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS: Wife: Vallie L. JENKINS

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchial Pneumonia	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Stomach with extensive metastasis	
	(c) Cachexia, Severe.	

151x
46 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease & decompensation

19a. DATE OF OPERATION: 5/15/50

19b. MAJOR FINDINGS OF OPERATION: Exploratory Laparotomy, Inoperative Gastric Carcinoma

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5, 1950, to Sept 22, 1950, that I last saw the deceased alive on Sept 22, 1950, and that death occurred at 9:45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. R. Baldwin	J. R. BALDWIN, LTJG, MCR, USNR.	US. NAVAL HOSPITAL	September 22, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 26, 1950	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 22, 1950	Edith Whittington	S. H. Hines Funeral Home	2901 14th Street, NW, Washington, D.C.

60896

RECEIVED
SEP 23 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09374

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CHEVY CHASE
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5611 WISCONSIN AVE. FRIENDSHIP REST HOME

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE WASHINGTON COUNTY D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 3115 44TH ST. N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) HILDA (Middle) A. (Last) JOHNSON

4. DATE OF DEATH: (Month) SEPT. (Day) 26 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH: OCT. 15, 1862

9. AGE last birthday: 87 yrs. If under 1 year: Months 11 Days 11 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): AUSTIN, MINN.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LEWIS ANDERSON

14. MOTHER'S MAIDEN NAME: SOPHIA JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: BETHESDA, MD. HAZEL CHAMBLISS - 4518 AVONDALE ST.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X **Immediate cause** (a) Cerebral Thrombosis with paralysis of right arm and leg

83b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH: 24 hours

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 4 years

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED Whiie at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950, to Sept 26, 1950, that I last saw the deceased alive on Sept 26, 1950, and that death occurred at 11:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E. Herbert Bauersfeld M.D. 1912 R. St. N.W. Sept 26, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9-29-50 NAME OF CEMETERY OR CREMATORY ROCK CREEK LOCATION (City, town, or county) (State) Wash D. C.

DATE REC'D BY LOCAL REG. 9/27/50 REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR ADDRESS The S. H. Hines Co. 2901 14th St. N.W.

RECEIVED
SEP 30 1950
BUREAU V. S

Evidence for addition in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09375

CERTIFICATE OF DEATH

FILE No. G 126 SEP 18 1950

Reg. Dist. No. 223-

1. PLACE OF DEATH: COUNTY Montgomery — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park — LENGTH OF STAY (in this place) 5 mo. - 20 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington.
STREET ADDRESS (If rural, give location) 519 Roxboro Pl. N.W. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mrs. Virginia	McS	Jones.	Sept.	4	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Fe.	W.	Widowed	11-8-64	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Wash. D.C.	Amer.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Zerobabel Kellum.	Penelope Butt.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No.			Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

1998 **Immediate cause** (a) Acute cardiac Failure

55e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Carcinomatosis (Primary site unknown 9/15/50 ac)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug 12, 1947, to Sept 4, 1950, that I last saw the deceased alive on Sept 4, 1950, and that death occurred at 11:40 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Dean H. Harding MD.		113 Carroll St NW Wash DC	9-4-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF.	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	9/7/50	Arlington Nat Cem	Arlington. Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/5/50.	J. Milton Dodd	W. W. Hamburg Co.	Wash. D.C.

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 18 1980
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

09376

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs; MARYLAND; LENGTH OF STAY (in this place) 4 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 1203 Brookville Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs Md.; STREET ADDRESS (If rural, give location) 1203 Brookville Rd.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Thomas	James	Kenned[illegible]	Sept	7	1950

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Married	2 June 1889	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician	U.S. Navy	Massachusetts	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Kenned[illegible]	Mary Connor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes		Thos. J. Kennedy, Jr. M.D.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary Thrombosis	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary Arteriosclerosis	5 years
(c)		

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Emil G. Bauernfeind	M.D.	7345 Wisconsin Ave Bethesda Md	Sept 7 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Sept 11/50	Arlington Natl Cem	Arlington	Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/8/50	Frances Potter	Frances J. Collins	3821 - 14th St N.W. Wash DC

V3292

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 13 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09377

CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OLNEY
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Germantown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Baby Girl (Middle) (Last) Knight

4. DATE OF DEATH (Month) (Day) (Year) September 28 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 9/28/50

9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours 10 Min. 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Preston Leroy Knight

14. MOTHER'S MAIDEN NAME Clara Lind Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X Immediate cause (a) Premature birth — Interval Between Onset and Death: 10 hrs

159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/28, 19 50, to 9/30, 19 50 that I last saw the deceased alive on 9/30, 1950, and that death occurred at 5:40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. D. Bonyard M.D. Sandy Spring Md. 9/30/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Sept 30, 1950

NAME OF CEMETERY OR CREMATORY Jennings Chapel

LOCATION (City, town, or county) (State) Howard Co. Maryland

DATE REC'D BY LOCAL REG. 9-30-50

REGISTRAR'S SIGNATURE Gertrude B Fowler

24. FUNERAL DIRECTOR ADDRESS Roy W Barber Laytonsville, Md.

2-0-9-28-0-21-2-40-1-

RECEIVED
OCT 2 1980
BUREAU OF

Evidence for changes in #23 & 24 shown on:

09378

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 1 28 SEP 20 1950 **CERTIFICATE OF DEATH**

Reg. Dist. No. 215

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural; LENGTH OF STAY (in this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington; STREET ADDRESS (If rural, give location) 1429 Perry Place, N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Barbara (none) (Middle) ~~Elizabeth~~ Jacqueline (none) "B" (Last) KODIS

4. DATE OF DEATH: (Month) (Day) (Year) September 9, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 6, 1950

9. AGE last birthday: 00 yrs. If under 1 year: Months 00 Days 03 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Anthony "J" KODIS

14. MOTHER'S MAIDEN NAME: Claire GOYETTE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS: Mother: Claire G. KODIS

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) immaturity — Interval between onset and death: 3d.

760.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

160a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Sub dural Hemorrhage

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 6, 1950, to Sept. 9, 1950, that I last saw the deceased alive on Sept. 9, 1950, and that death occurred at 6:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

S. G. WINTER, CDR, MC, USN U.S. NAVAL HOSPITAL September 11, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) ~~Disposal~~ Burial DATE THEREOF 14 Sept. 1950 NAME OF CEMETERY OR CREMATORY ~~USN Medical School~~ Arlington National LOCATION (City, town, or county) Bethesda, ~~Maryland~~ Va. (State)

DATE REC'D BY LOCAL REG. Sept. 11, 1950 REGISTRAR'S SIGNATURE Ercel Whittington

24. FUNERAL DIRECTOR ADDRESS Robertson-Pumphrey, Bethesda, Md.

2-1-9-06-0-20-2-34-2

RECEIVED
SEP 13 1950
BUREAU V.S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09379

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County General Hospital, Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 2205 California St. N.W. ✓

3. NAME OF DECEASED (Type or Print) (First) James (Middle) W. (Last) Kyle
4. DATE OF DEATH (Month) Sept. (Day) 19 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M.
8. DATE OF BIRTH 3/29/75
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Martin Varnish Co.
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME R.P.Kyle
14. MOTHER'S MAIDEN NAME Ellen Curd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY No. unknown
17. INFORMANT AND ADDRESS From hospital chart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Shock

610x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Simple Prostatic Hypertrophy

137a (c) Post operation

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 9/19/50
19b. MAJOR FINDINGS OF OPERATION Hypertrophy of Prostate
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ✓
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓ (CITY OR TOWN) ✓ (COUNTY) ✓ (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ✓ m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from 9/16, 1950, to 9/19, 1950, that I last saw the deceased alive on 9/19, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE J.W. Bird (Degree or title) M.D. ADDRESS Sandy Spring Md DATE SIGNED 9/19/50

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 9/22/50 NAME OF CEMETERY OR CREMATORY Fairview Cem. LOCATION (City, town, or county) Roanoke (State) Va.

DATE REC'D BY LOCAL REG. 9/20/50 REGISTRAR'S SIGNATURE Francis Potter
24. FUNERAL DIRECTOR Joseph Lawrenson ADDRESS 1759 Pa. Ave. Wash. D.C.

27815

RECEIVED
SEP 23 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09380

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park | LENGTH OF STAY (In this place) 10 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 8427 Dale St. Silver Spring

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) C. (Last) Leeman
4. DATE OF DEATH: (Month) Sept (Day) 3 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Fe	White	Widowed	Nov 3 1879	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework	Own Home	Ala.	

13. FATHER'S NAME John Caffiby
14. MOTHER'S MAIDEN NAME Mary Foxworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	none	Grace L. Waterman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	1/2 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank J. Brockhurst	M.D.	Gaithersburg Md	9-3-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 6, 1950	Rock Creek Cemetery	Washington, D. C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/5/50	[signature]	Warner E. Pumphrey	8434 Ga. Ave., Silver Spring, Md.

RECEIVED
SEP 8 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09381

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bethesda & Arlington Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 304 L Street, S.W.

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) (Last) Lewis
4. DATE OF DEATH (Month) Sept. (Day) 6 (Year) 1950
5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH April 10, 1910
9. AGE last birthday 40 yrs. If under 1 year: Months 4 Days 26 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Contsruction Co.
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alfred Lewis
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II
16. SOCIAL SECURITY NO. 578-38-8540
17. INFORMANT Clara Lewis Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

914.5 Immediate cause (a) Electrocution (accidental) — INTERVAL BETWEEN ONSET AND DEATH: Instantaneous

193 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY street (CITY OR TOWN) Bethesda (COUNTY) Montgomery Co. (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 6, 1950 4 p m.
INJURY OCCURRED While at work ☑ Not while at work ☐
HOW DID INJURY OCCUR? Touched coarse in contact with high tension wire

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Emil G. Bauersfeld M.D. (Degree or title) Sub Dep. Med. Exam. Mont. Co. Md. ADDRESS Bethesda, Md DATE SIGNED 9/6/1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 9-11-50 NAME OF CEMETERY OR CREMATORY Arlington LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. 9-6-50 REGISTRAR'S SIGNATURE Helen Kurweck
24. FUNERAL DIRECTOR Eugene Ford ADDRESS 1213-4th St. S.

988V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 11 1950
BUREAU F. S

09382

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH · COUNTY Monty. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE ~~Linden~~ Md. COUNTY Monte
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Zion — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linden -
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location) Silver Spring

3. NAME OF DECEASED (Type or Print) (First) Henry (Middle) (Last) Lewis			4. DATE OF DEATH (Month) Sept (Day) 9 (Year) 1950		
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1885? Unknown.	9. AGE last birthday 65? yrs.	If under 1 year Months / Days — If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Unknown.			14. MOTHER'S MAIDEN NAME Unknown -		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2	Immediate cause	(a) Congestive heart failure	1 wk
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 2, 1950, to Sept 9, 1950, that I last saw the deceased alive on Sept 9, 1950, and that death occurred at 10:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. D. Bonifacet	M.D.	Sandy Spring Md.	9/11/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 9/12/50	NAME OF CEMETERY OR CREMATORY Church Cemetery	LOCATION (City, town, or county) Linden - SS. (State) Md.
DATE REC'D BY LOCAL REG. 9-12-50	REGISTRAR'S SIGNATURE Gertrude B Lawler	24. FUNERAL DIRECTOR R. L. Snowden, Rockville, Md	ADDRESS

74099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 14 1950
BUREAU

09383

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville, rural
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS River Road near Travilah Route 1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville, rural Route 1
STREET ADDRESS (If rural, give location) River Road near Travilah

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Henry (Last) Lockwood

4. DATE OF DEATH (Month) September (Day) 13 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Dec. 13, 1873
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinary, retired
10b. KIND OF BUSINESS OR INDUSTRY Veterinary medicine
11. BIRTHPLACE (State or foreign country) Carlton, N. Y.
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME John Thomas Lockwood.
14. MOTHER'S MAIDEN NAME Rose Anna Callahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT AND ADDRESS Miss Eliz. Louise Lockwood, 4621 5th St. N.W., Hasle, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
450.0	Immediate cause	(a) Uremia	Few days.
97	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	10 years
		(c) Prostatectomy 1947-	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none.

19a. DATE OF OPERATION Sept. 1947-
19b. MAJOR FINDINGS OF OPERATION Transurethral prostatectomy
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1949, to Sept. 13, 1950, that I last saw the deceased alive on Sept. 12, 1950, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

SIGNATURE Wm. A. Linthicum, M.D. (Degree or title) ADDRESS Rockville, Md. DATE SIGNED 9/13/50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/16/50
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) Suitland, Md. (State)

DATE REC'D BY LOCAL REG. 9-13-50
REGISTRAR'S SIGNATURE Helen Kurrack
24. FUNERAL DIRECTOR F. J. Saffell ADDRESS 475-H-N.W.

V5092 D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 15 1950
BUREAU V. S

09384

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place): 15 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: none

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural give location): 9305 Pendleton Drive

3. NAME OF DECEASED (Type or Print): (First) AGNES (Middle) RICHARDSON (Last) LOROMER

4. DATE OF DEATH: (Month) 9 (Day) 23 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 12/14/1885

9. AGE last birthday: 64 yrs. — If under 1 year: Months 9 Days 9 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): SWEDEN

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: RICHARD GUSTAVSON

14. MOTHER'S MAIDEN NAME: UNKNOWN TO INFORMANT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: (DAUGHTER) Edith O'Neill

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CORONARY THROMBOSIS	1 year
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ESSENTIAL HYPERTENSION	
420.1 940	(c) (ARTHRITIS)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): natural

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

(CITY OR TOWN) Silver Spring (COUNTY) Montgomery (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 23, 1950 6 m. PM

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? Coronary thrombosis

22. I hereby certify that I attended the deceased from 9/23, 19 50, to 9/23, 19 50, that I last saw the deceased alive on 9/23, 19 50, and that death occurred at 5 15 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Belden R. Reap	M.D.	2601 Elnora St. Silver Spring	Md.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
CREMATION	9/25/50	Ft. Lincoln Crematory	Pr. George's Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/25/50	Frances Potter	Warner E. Pumphrey Sons	Silver Spring, Md.

(See reverse side — BRR)

VS. A15

Note: Dr. M. Cuvillier was taking care of this patient and because he was unable to see her yesterday he requested that I do so for him. Dr. F. Broschart, County Medical Examiner (Montgomery County, Md.) was contacted and authorized me to execute this certificate.

B R Leap, M.D.
9/24/50

RECEIVED
SEP 27 1950
BUREAU

09385

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenview Farm

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; STREET ADDRESS (If rural, give location) Glenview Farm

3. NAME OF DECEASED (Type or Print): (First) Irene (Middle) Elizabeth Moore (Last) Lyon

4. DATE OF DEATH: (Month) Sept. (Day) 23 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 10, 1881

9. AGE last birthday: 69 yrs. If under 1 year: Months 5; Days 13; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John William Moore

14. MOTHER'S MAIDEN NAME: Elizabeth Stauffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Dr. James A. Lyon, Glenview Farm, Rockville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral vascular accident (embolus?)	3 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 331 x 92 c	(b) Chronic rheumatic endocarditis	Many years
	(c) Arteriosclerosis & hypertension	10 years.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic lipoid pneumonia	?

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: Cholecystectomy several years ago.

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While) At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 20, 1950, to Sept. 23, 1950, that I last saw the deceased alive on Sept. 22, 1950, and that death occurred at 8:58 A. m., from the causes and on the date stated above.

SIGNATURE: Wm A. Linthicum, M.D. (Degree or title) ADDRESS: Rockville, Md. DATE SIGNED: 9/23/50.

23. BURIAL, CREMATION REMOVAL (Specify): Cremation; DATE THEREOF: Sept. 24/50; NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory; LOCATION (City, town, or county): Washington (State): D.C.

DATE REC'D BY LOCAL REG. 9/26/50; REGISTRAR'S SIGNATURE: Peggy U. Veazey

24. FUNERAL DIRECTOR: Lewis A. Pumphrey; ADDRESS: Bethesda, Md

VS. A15

RECEIVED
SEP 28 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09386

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7 / 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Montg. Co, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place) 13Da
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montg.Co, General Hosp,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Germantown, R F D Cedar Grov
STREET ADDRESS (If rural, give location) -ve

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Machlotta

4. DATE OF DEATH: (Month) 9 (Day) 11 (Year) 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Feb 4/1867

9. AGE last birthday: 83 yrs. If under 1 year: Months. 7 Days 7 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: ""

11. BIRTHPLACE (State or foreign country): Albany, N Y.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Edward Judge

14. MOTHER'S MAIDEN NAME: Mary Kelleher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Fracture, femur, left, inter and extra trochanteric. — Interval between onset and death: 10 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease Senility — Unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT ✓ SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home (CITY OR TOWN) Germantown Rte 1 (COUNTY) Mont (STATE) Md.

TIME OF INJURY (Month) Sept. (Day) 2 (Year) 1950 (Hour) 7:30 a.m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Fell while arising from bed

22. I hereby certify that I attended the deceased from Sept. 2, 19 50, to Sept. 11, 19 50, that I last saw the deceased alive on Sept. 11, 19 50, and that death occurred at 5.09 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jack Schumacher M.D. Gaithersburg Md. Sept. 13, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 9/14/50 | NAME OF CEMETERY OR CREMATORY: St. Rose, Cemetery | LOCATION (City, town, or county) (State): Clopper, Md,

DATE REC'D BY LOCAL REG.: Sept. 13, 1950 | REGISTRAR'S SIGNATURE: Ethel L. Cooke

24. FUNERAL DIRECTOR ADDRESS: Ernest C. Gartner, Gaithersburg. Md,

RECEIVED
SEP 15 1950
BUREAU V. S.

09387

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BETHESDA — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: SUBURBAN HOSPITAL, 8600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Springs
STREET ADDRESS (If rural, give location): 12210 Selfridge Rd. Views Hills Village

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Wendell E. Mayer
4. DATE OF DEATH (Month) (Day) (Year): Sept. 19 1950

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Dec. 2, 1907
9. AGE last birthday: 42 yrs. — If under 1 year: Months 10 Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ✓
10b. KIND OF BUSINESS OR INDUSTRY: Upholsterer
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jacob Mayer
14. MOTHER'S MAIDEN NAME: Marie Wayner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X (If year, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT AND ADDRESS: Mrs. Eva Mayer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

411 x Immediate cause (a) Congestive Heart Disease — 1 year

Antecedent cause(s)

92 a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Valvular Heart Disease, Aortic Insufficiency — 22 years

(c) Rheumatic Heart Disease — 36 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 29, 1948, to Sept. 19, 1950, that I last saw the deceased alive on Sept. 18, 1950, and that death occurred at 5:30 A.m., from the causes and on the date stated above.

SIGNATURE: Robert G. Angle M.D. (Degree or title) — ADDRESS: 106 Del Ray Ave Bethesda, Md — DATE SIGNED: Sept 19, 1950

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE: 9/23/50 — NAME OF CEMETERY OR CREMATORY: Holy Cross Cem. — LOCATION (City, town, or county) (State): A.A. Co., Md.

DATE REC'D BY LOCAL REG. 9-20-50 — REGISTRAR'S SIGNATURE: Helen Kurvack — 24. FUNERAL DIRECTOR: John F. Denny, Inc. — ADDRESS: 715 Light St.

36485

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

Received
SEP 22 1950
Bureau of V. S.

09388

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural — LENGTH OF STAY (in this place): 2½ hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Virginia — COUNTY: Arlington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: North Arlington
STREET ADDRESS (If rural, give location): 612 North Fillmore Street ✓

3. NAME OF DECEASED (Type or Print): Mary (First) ~~(none)~~ (Middle) Jeanne (Last) MC CABE

4. DATE OF DEATH (Month) (Day) (Year): September 21, 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Sept. 21, 1950
9. AGE last birthday: 00 yrs. — If under 1 year: Months 00, Days 00 — If under 24 hrs.: Hours 2, Min. 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John N. MC CABE
14. MOTHER'S MAIDEN NAME: Parma Lee EASTMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY No.: - - - - -
17. INFORMANT AND ADDRESS: Mother: Parma Lee MC CABE

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Immaturity

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Premature separation placenta 2 weeks

(c) Placental infarction unknown

761.5

160c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 21, 1950, to Sept. 21, 1950, that I last saw the deceased alive on Sept. 21, 1950, and that death occurred at 9:35 A.m., from the causes and on the date stated above.

SIGNATURE: L. M. Harris (Degree or title) ADDRESS: L. M. HARRIS, CAPTAIN, MC, USN U.S. NAVAL HOSPITAL — DATE SIGNED: September 25, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Disposition — DATE THEREOF: Sept 25, 1950 — NAME OF CEMETERY OR CREMATORY: USN Medical School — LOCATION (City, town, or county) (State): Bethesda, Maryland

DATE REC'D BY LOCAL REG.: Sept 25, 1950 — REGISTRAR'S SIGNATURE: Edith Whittington — 24. FUNERAL DIRECTOR: None — ADDRESS

2-0-9-21-0-23-2-22-0

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 27 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0938?

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1901 Lansdowne Way

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 1901 Lansdowne Way

3. NAME OF DECEASED (Type or Print): (First) Ruth (Middle) Colvin (Last) Mc Guire

4. DATE OF DEATH: (Month) Sept (Day) 2 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Feb 19-1893

9. AGE last birthday: 57 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Plant Cytologist

10b. KIND OF BUSINESS OR INDUSTRY: Govt. Agriculture Dept.

11. BIRTHPLACE (State or foreign country): Flora Ind

12. CITIZEN OF WHAT COUNTRY: Usa

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Charles Raymond Mc Guire

18. MEDICAL CERTIFICATION 1901 Lansdowne Way, Silver Spring, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175x **Immediate cause** (a) Malignant Granulosa Cell Tumor — INTERVAL BETWEEN ONSET AND DEATH: about 4 years.

49a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) 1 ovary with generalized peritoneal metastases and ascites
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1-29-47 + 5-17-49
19b. MAJOR FINDINGS OF OPERATION: Granulosa cell tumor 1 ovary with metastases
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Mooth) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24, 1947, to 9-2, 1950, that I last saw the deceased alive on 5-29, 1950, and that death occurred at 5.25 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Deane C. Richtmeyer M.D. 1435 Eye Street, N.W. Washington 6, D.C. 9-2-50.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Sept. 6, 1950
NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
LOCATION (City, town, or county) (State): Fort Myer, Va.

DATE REC'D BY LOCAL REG. 9/6/50
REGISTRAR'S SIGNATURE: Frances Potter
24. FUNERAL DIRECTOR ADDRESS: Warner C. Pumphrey, 8434 Ga. Ave., Silver Spring, Md..

V 5298

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-2-50

Corner notified & approved

Duane C. Richtwerger M.D.

RECEIVED
SEP 11 1950
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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MARYLAND STATE DEPARTMENT OF HEALTH

09390

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (In this place) 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10407 Barrie Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 10407 Barrie Ave

3. NAME OF DECEASED (Type or Print) (First) Murdoch (Middle) John (Last) McLeod
4. DATE OF DEATH (Month) Sept (Day) 2 (Year) 1950

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 4-28-'10
9. AGE last birthday 40 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Major U.S.A.
10b. KIND OF BUSINESS OR INDUSTRY A. Chem. corps
11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles H McLeod
14. MOTHER'S MAIDEN NAME Maud Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Virginia McLeod (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden death.

9 ta Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 9-2-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-5-50
NAME OF CEMETERY OR CREMATORY Arlington Nat.
LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG 9/4/50
REGISTRAR'S SIGNATURE Frances Potter
24. FUNERAL DIRECTOR Wastler Funeral Home, ADDRESS 301 E. Cap. St. 11296 Washington D.C.

RECEIVED
SEP 7 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Copy 09391

Reg. Dist. No. 223-

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 2701 14th St. N. W. ✓

3. NAME OF DECEASED (Type or Print) (First) Mrs. (Middle) Margaret (none) (Last) Morcock

4. DATE OF DEATH (Month) 9 (Day) 12 (Year) 1950

5. SEX Fe
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH 7-11-70
9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Thomastown, Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Julius Williams
14. MOTHER'S MAIDEN NAME Josephine Worthy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153x Immediate cause (a) Adenocarcinoma of Cecum with massive

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

46e (b) metastasis to liver.

(c) Diverticulosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diverticulosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-12, 1950, to 9-12, 1950, that I last saw the deceased alive on 9-12, 1950, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
De Voe K. Meade M.D. Takoma Park 12 Md 9-13-50

23. BURIAL, CREMATION REMOVAL (Specify)
DATE THEREOF Sept-15-1950
NAME OF CEMETERY OR CREMATORY Rock Creek Cem
LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. 9/13/50
REGISTRAR'S SIGNATURE J. Wilson Dodd
24. FUNERAL DIRECTOR S H Hines Co ADDRESS 2901-14th N W Wash. D.C.

RECEIVED
SEP 14 1950
BUREAU V. S

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09392

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Montg MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
LENGTH OF STAY (in this place) 80yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location) 3. Maryland Ave

3. NAME OF DECEASED (Type or Print) (First) Alice (Middle) Victoria (Last) Mullican
4. DATE OF DEATH (Month) 9 (Day) 14 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH Nov 17th/1869
9. AGE last birthday 80 yrs. If under 1 year Months 9 Days 27 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY W
11. BIRTHPLACE (State or foreign country) Gaithersburg Md,
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Henry Ward
14. MOTHER'S MAIDEN NAME Laura Ricketts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Family Record, Geneva Mullican

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ✓
19b. MAJOR FINDINGS OF OPERATION ✓
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) ✓
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓ (CITY OR TOWN) ✓ (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ✓ m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ ✓
HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from Sept-12, 1950, to Sept-14, 1950, that I last saw the deceased alive on Sept-14, 1950, and that death occurred at 10 30/P m., from the causes and on the date stated above.

SIGNATURE William C Miller, M.D., (Degree or title) ADDRESS 7-Brooks Ave., Gaithersburg, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9/16/50
NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery
LOCATION (City, town, or county) Gaithersburg Md, (State)

DATE REC'D BY LOCAL REG. Sept. 16, 1950
REGISTRAR'S SIGNATURE Alverda G Cooke
24. FUNERAL DIRECTOR Ernest C. Gartner. ADDRESS Gaithersburg Md,

RECEIVED
SEP 19 1950
BUREAU V. I.

09393

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 1 mo 2 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 717 24th Street, N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Clarence (Middle) Henry (Last) NICHOLS

4. DATE OF DEATH: (Month) (Day) (Year) September 18, 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 6, 1896

9. AGE last birthday: 54 yrs. — If under 1 year: Months 06 — Days 13 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William H. NICHOLS

14. MOTHER'S MAIDEN NAME: Mary BAPTIST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS: Wife: Maud A. NICHOLS

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Embolism	10 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (420.0 938)	(b) Coronary Thrombosis (Right Coronary A.)	60 minutes
	(c) Coronary Arteriosclerotic Heart Disease	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 17, 1950 to Sept. 18, 1950, that I last saw the deceased alive on Sept. 18, 1950, and that death occurred at 2:30 Am., from the causes and on the date stated above.

SIGNATURE A. E. Marland — (Degree or title) A. E. MARLAND, LTJG, MC, USN — ADDRESS U.S. NAVAL HOSPITAL — DATE SIGNED September 18, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Sept. 20, 1950 | NAME OF CEMETERY OR CREMATORY Arlington National | LOCATION (City, town, or county) Arlington, Virginia (State)

DATE REC'D BY LOCAL REG. Sept. 18, 1950 | REGISTRAR'S SIGNATURE Edith Whittington

24. FUNERAL DIRECTOR — ADDRESS Malvan & Schey, 424 R Street, NW, Washington, D. C.

A.B.K.

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RECEIVED
SEP 20 1950
BUREAU U.S.

09394

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) (Last) Offutt

4. DATE OF DEATH: (Month) Sept. (Day) 10, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: ? 1883

9. AGE last birthday: 67 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labour

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Offutt

14. MOTHER'S MAIDEN NAME: Annie Joppy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Margaret Offutt (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral accident	2 days
331X Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? ~~Yes~~ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/8, 1950, to 9/10, 1950, that I last saw the deceased alive on 9/10, 1950, and that death occurred at 7:20 P. m., from the causes and on the date stated above.

SIGNATURE: Dora Lan (Degree or title) M.D. ADDRESS: Suburban Hospital DATE SIGNED: 9/10/50.

23. BURIAL, CREMATION REMOVAL (Specify) — DATE: 9-13-50 — NAME OF CEMETERY OR CREMATORY: Oak Grove, — LOCATION (City, town, or county): Mt Zion, (State) Md

DATE REC'D BY LOCAL REG.: 9-12-50 — REGISTRAR'S SIGNATURE: Helen Kurvack — 24. FUNERAL DIRECTOR: R. L. Snowden, Rockville, Md. ADDRESS

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 15 1960
BUREAU U. S

09395

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washe San. & Hospital Takoma Park 12, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Stephens City, Va.
STREET ADDRESS (If rural, give location) Rt. #1

3. NAME OF DECEASED (Type or Print) (First) Elmer (Middle) Rendolph (Last) Peer

4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 8-27-80
9. AGE last birthday 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Owner
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Cedar Creek, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Peer
14. MOTHER'S MAIDEN NAME Mary Brill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Vera Brooks Peer 7225 Flower Ave Tak Pk Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
610X	Immediate cause	(a) Right Pulmonary Embolism	8 hrs
	Antecedent cause(s)		
137a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Phlebothrombosis of popliteal vessels	2 days
		(c) Benign Prostatic Hypertrophy with Transurethral resection.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 9-25-50
19b. MAJOR FINDINGS OF OPERATION Prostatic enlargement & Calculi
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1950, to Oct. 9, 1950, that I last saw the deceased alive on Oct. 8, 1950, and that death occurred at 5:35 a.m., from the causes and on the date stated above.

SIGNATURE De Voe K. Meade M.D. (Degree or title) ADDRESS Takoma Park 12, Md. DATE SIGNED 10-9-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Oct 11, 1950
NAME OF CEMETERY OR CREMATORY River View Cem
LOCATION (City, town, or county) Strasburg, (State) Va

DATE REC'D BY LOCAL REG. Oct 9-1950
REGISTRAR'S SIGNATURE J. Helms Dodd
24. FUNERAL DIRECTOR Arthur Walberg ADDRESS 254 Carroll St NW Takoma Park D.C.

000 VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 11 1950
BUREAU V. S

09396

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park — LENGTH OF STAY (in this place): 6 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: D.C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 6325 32nd St NW. D.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Achilles Pasquale Persion
4. DATE OF DEATH (Month) (Day) (Year): 9 - 29 - 1950

5. SEX: M
6. COLOR OR RACE: Italian
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: 9-2-1882
9. AGE last birthday: 68 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sec. Treasure Labor Union
10b. KIND OF BUSINESS OR INDUSTRY: Int. Hod Carriers Union
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Persion
14. MOTHER'S MAIDEN NAME: Adelia Iaroussi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerosis general, Cerebral c̄ Hemorrhage & Lft Hemoplegia

420.1 Antecedent cause(s)

95c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension c̄ Coronary Atherosclerosis, Angina Pectoris;

(c) Left ventricular hypertrophy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION: 0
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify): 0
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): 0 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from seventy, 19..., to 9/29/, 1950, that I last saw the deceased alive on 9/29, 1950, and that death occurred at 7 23 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
[signature] H. Holohan, MD 500 Underwood St NW Washington, D.C. 9/29/50

23. BURIAL, CREMATION REMOVAL (Specify) — DATE: 10/3/50 — NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem — LOCATION (City, town, or county): Pr Georges Co. (State): Md.

DATE REC'D BY LOCAL REG.: 9/29/50 — REGISTRAR'S SIGNATURE: J. Wilm Dodd
24. FUNERAL DIRECTOR: The S. H. Hines Co. — ADDRESS: 2901-14th St N.W. Washington D.C.

156 94

Cornell's Permission
Dr Bruschard authorized signing these
certificates at the Iowa only Chem - Sanitation.
Chas H Holden

RECEIVED
SEP 30 1950
BUREAU V. S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09397

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Comus; LENGTH OF STAY (in this place) 3 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montg.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Comus; STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Ethel; (Middle) E.; (Last) Philip

4. DATE OF DEATH: (Month) 9; (Day) 16; (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 30 - 1900

9. AGE last birthday: 49 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Entwisle

14. MOTHER'S MAIDEN NAME: Jessie Doney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Barrett Philip

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
331X	Immediate cause (a) Massive Cerebral Hemorrhage secondary to Cerebro vascular accident	one half hour
83a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension ~~Cardio~~ Renal; Malignant	3 years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to 16 Sept, 1950, that I last saw the deceased alive on 16 Sept, 1950, and that death occurred at 11 30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gordon McSmith	M.D.	Barnesville, Md	17 Sept 50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/19/50	Naval Academy Cem.	Annapolis Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/18/50	Mrs. C. C. Hilton By Mrs. C. C. H.	Edw. B. Hilton	Barnesville Md.

RECEIVED
SEP 30 1950
U. S. PATENT OFFICE

09398

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County Genl. Hosp. Olney, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Brookeville COUNTY Mont
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) Olney, Md.

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) S. (Last) Pollen ✓
4. DATE OF DEATH (Month) Sept. (Day) 8, (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH March 2, 1867
9. AGE last birthday 83 87 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Reeves
14. MOTHER'S MAIDEN NAME Charlotte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Self

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Adenocarcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 9 months

181X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

52b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Aug. 14, 1950
19b. MAJOR FINDINGS OF OPERATION Bladder Cancer, Hydronephrosis Hydrometers
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to Sept. 8, 1950, that I last saw the deceased alive on Sept. 7, 1950, and that death occurred at 3:09 a m., from the causes and on the date stated above.

SIGNATURE Jack Schumacher (Degree or title) M.D. ADDRESS Gaithersburg, Md. DATE SIGNED Sept. 8, 1950

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) Burial
DATE THEREOF 9/11/50
NAME OF CEMETERY OR CREMATORY Glenwood Cem.
LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. 9-8-50
REGISTRAR'S SIGNATURE Gertrude B. Lawler (R.F.)
24. FUNERAL DIRECTOR W.W. Chambers Co ADDRESS 1400 Chapin St. Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
SEP 14 1950
BUREAU V. S

09399

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 213

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
LENGTH OF STAY (in this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 102 N.Van Buren St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
STREET ADDRESS (If rural, give location) 102 N.Van Buren St.

3. NAME OF DECEASED (Type or Print) (First) Laura (Middle) Alice (Last) Poole
4. DATE OF DEATH (Month) Sept (Day) 20 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 28 Aug.1881
9. AGE last birthday 69 yrs. If under 1 year Months 0 Days 2 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ezrq Wetzel
14. MOTHER'S MAIDEN NAME Emily Vann
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Miss Urna Mae Poole 102 N.Van Buren Rockville,Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary occlusion — ½ hr.

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.* Time of death 1.45 a.m. (P.)

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 9-20-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 23 Sept.1950
NAME OF CEMETERY OR CREMATORY Rockville Union
LOCATION (City, town, or county) Rockville, Md. (State)

DATE REC'D BY LOCAL REG. 9/22/50
REGISTRAR'S SIGNATURE Peggy U. Veazey
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda,Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 28 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09400

CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brookeville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Austin (Middle) Thompson (Last) Powell

4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 5/27/68

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Austin Powell

14. MOTHER'S MAIDEN NAME: Emily Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive heart failure — Interval between onset and death: 7 days

422.2

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic myocarditis — 3 yrs

934

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/29, 1950, to 9/2, 1950, that I last saw the deceased alive on 9/2, 1950, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE: [signature] M.D. (Degree or title) ADDRESS: Sandy Spring Md DATE SIGNED: 9/2/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept. 4, 1950
NAME OF CEMETERY OR CREMATORY: Brookeville Church Cemetery
LOCATION (City, town, or county) (State): Brookeville, Md.

DATE REC'D BY LOCAL REG.: 9-3-50
REGISTRAR'S SIGNATURE: Gertrude B Lawler

24. FUNERAL DIRECTOR: Warner E. Pumphrey
ADDRESS: 8434 Georgia Ave., Silver Spring, Md.

RECEIVED
SEP 18 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09401

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural — LENGTH OF STAY (in this place) 1 yr 7½ mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 423 Emerson Street, NW ✓

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (n) (Last) PREZZIOTTI
4. DATE OF DEATH (Month) (Day) (Year): September 20, 1950
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 25, 1895
9. AGE last birthday: 55 yrs. — If under 1 year: Months 03 — Days 16 — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? US (N)
13. FATHER'S NAME: Richard PREZZIOTTI
14. MOTHER'S MAIDEN NAME: Maria LAGROSLA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO.: - - - - - - - - -
17. INFORMANT AND ADDRESS: Wife: Helen PREZZIOTTI

18. MEDICAL CERTIFICATION — Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
332 Immediate cause	(a) Bronchopneumonia, Terminal	2 wks
830 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Anterior cerebral artery thrombosis, Right.	2 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 5, 1949, to Sept. 20 1950, that I last saw the deceased alive on Sept. 20, 1950, and that death occurred at 6:12 A m., from the causes and on the date stated above.

SIGNATURE: R. G. Berry — (Degree or title) LCDR, MC, USN — ADDRESS U.S. NAVAL HOSPITAL — DATE SIGNED September 21, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept. 22, 1950 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Sept. 21, 1950 — REGISTRAR'S SIGNATURE: Edith Whittington

24. FUNERAL DIRECTOR — ADDRESS: S. H. Hines, 2901 14th Street, NW, Washington, D.C.

20089 ABP

RECEIVED
SEP 22 1950
BUREAU V. I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09402

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 1 yr 5 mo 23 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 4339 Bowen Road, SE ✓

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Harold (Last) RHODES

4. DATE OF DEATH: (Month) (Day) (Year) September 14, 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec. 7, 1893

9. AGE last birthday: 56 yrs. If under 1 year: Months 09 Days 08 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hospital Attendant

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Harry RHODES

14. MOTHER'S MAIDEN NAME: Alice GRIGGS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT AND ADDRESS: Brother: Paul RHODES, 2418 Penn. Ave., NW, Wash., DC

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cirrhosis liver	indef.
	(c) Carcinomatosis, pharynx	indef.

148X
45f

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 22, 1949, to Sept. 14, 1950, that I last saw the deceased alive on Sept. 14, 1950, and that death occurred at 5:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

A.J. DELANEY, CAPTAIN, MC, USN U.S. NAVAL HOSPITAL Sept. 16, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Sept. 19, 1950

NAME OF CEMETERY OR CREMATORY: Arlington National

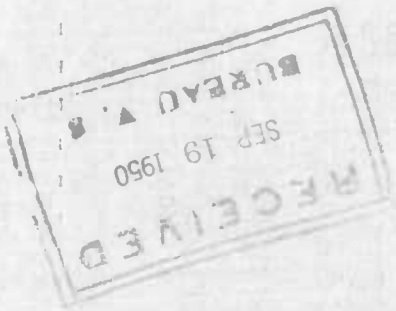
LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Sept. 16, 1950

REGISTRAR'S SIGNATURE: Edith Worthington

24. FUNERAL DIRECTOR: W. W. Chambers ADDRESS: 3072 M Street, NW, Washington, D.C.

19092


RECEIVED
SEP 19 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

09403

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville — LENGTH OF STAY (In this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 218 Monroe ST.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 218 Monroe St
STREET ADDRESS (If rural, give location) Rockville, Md.

3. NAME OF DECEASED (Type or Print): (First) Janet (Middle) Kelley (Last) Rice
4. DATE OF DEATH: (Month) Sept (Day) 8 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	Single	3 June 1929	21 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student - Univ.
10b. KIND OF BUSINESS OR INDUSTRY: of Md.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Lynch Rice
14. MOTHER'S MAIDEN NAME: Anna Fawsett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Alfred Noyes

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bullet Wound Right Temple c Hemorrhage — immediate

976X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

164c (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
(CITY OR TOWN) Rockville (COUNTY) Montgomery (STATE) Md.
TIME OF INJURY (Month) Sept (Day) 8 (Year) 1950 (Hour) 3:00 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Self inflicted Bullet Wound, Right Temple

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) Emil G. Bauerfeld, M.D. — ADDRESS 7345 Wisconsin Ave — DATE SIGNED 8 Sept 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	9/11/50	Darnestown Church Cem.	Darnestown,	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/11/50	Peggy H. Veazey	Robert A. Pumphrey	Bethesda, Md.

RECEIVED
SEP 13 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09404

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park — LENGTH OF STAY (in this place): 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Wash. San. + Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spings Md
STREET ADDRESS (If rural, give location): 100 Ames St. Rd.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Mrs. Vivielle Rodriguez

4. DATE OF DEATH (Month) (Day) (Year): 9 5 1950

5. SEX: F

6. COLOR OR RACE: Porto Rican-Spanish

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 12-9-75

9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Guayanilla - Puerto Rico

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Orlando LaVerune

14. MOTHER'S MAIDEN NAME: Adolfena Visarro

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Wash. San. Hosp. Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

157X Immediate cause (a) Shock - following exploratory operation

Antecedent cause(s)

46g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Adenocarcinoma of pancreas.

(c) Cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-1-50

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-20, 1950 to 9-5, 1950, that I last saw the deceased alive on 9/4/50, 1950, and that death occurred at 9:05 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Ernest E Harmon M.D. Takoma Park Md. SEP 5 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Sept. 6, 1950 — NAME OF CEMETERY OR CREMATORY: George Washington Memorial — LOCATION (City, town, or county) (State): Cem., Prince Geo. Co., Md.

DATE REC'D BY LOCAL REG.: 9/5/50 — REGISTRAR'S SIGNATURE: J. Wilson Dodd

24. FUNERAL DIRECTOR — ADDRESS: Warner E. Pumphrey, 8434 Ga. Ave., Silver Spring, Md.

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SEP '8 1950
BUREAU V. S

09405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 14 days, 17 hrs, 0 mins
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital 8600 Old Georgetown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural, give location) 7 W. Everett St.

3. NAME OF DECEASED (Type or Print) (First) Francis (Middle) Michael (Last) Ryan
4. DATE OF DEATH (Month) 9 (Day) 8 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Dec 24 1882
9. AGE last birthday 67 yrs. If under 1 year Months 8 Days 14 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant (retired)
10b. KIND OF BUSINESS OR INDUSTRY Self employed
11. BIRTHPLACE (State or foreign country) Walla Walla Wash.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Myra Ryan (daughter-in-law) 7 W. Everett St. Kensington, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Prostate with generalized Metastases — INTERVAL BETWEEN ONSET AND DEATH 3 yrs.

177 X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

51b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1947, to Sept 8, 1950, that I last saw the deceased alive on Sept 7, 1950, and that death occurred at 5:15 A.m., from the causes and on the date stated above.

SIGNATURE Stewart Wapp (Degree or title) MD ADDRESS 3921 Ingomar St Wash. D.C. DATE SIGNED 9-8-50

23. BURIAL, CREMATION REMOVAL (Specify) Transit Burial
DATE THEREOF 9/9/50
NAME OF CEMETERY OR CREMATORY Catholic Cemetery
LOCATION (City, town, or county) (State) Walla Walla - Washington
DATE REC'D BY LOCAL REG. 9-9-50
REGISTRAR'S SIGNATURE Helen Kurrack
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Md.

21099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 13 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09406

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 6922 - Arlington Road

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) D. (Last) SADLER
4. DATE OF DEATH (Month) Sept. (Day) 16 (Year) 1950

5. SEX Male
6. COLOR OR RACE wh.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Nov 8, 1896
9. AGE last birthday 53 yrs. If under 1 year Months 9 Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Lawyer
11. BIRTHPLACE (State or foreign country) Ogdensburg N. Y.
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME John T. Sadler
14. MOTHER'S MAIDEN NAME Kathryne Ralph

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) World 1
16. SOCIAL SECURITY NO. No
17. INFORMANT AND ADDRESS Mrs La Rue Sadler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	3 hrs.
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	Unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1945, to Sept 16, 1950, that I last saw the deceased alive on Sept 14, 1950, and that death occurred at 1245 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Lee I. Donovan MD 8016 Georgetown Road Beth Md 9/16/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept 20/50
NAME OF CEMETERY OR CREMATORY St Johns Forrest Glen
LOCATION (City, town, or county) (State) Forrest Glen Md.

DATE REC'D BY LOCAL REG. 9-16-50
REGISTRAR'S SIGNATURE Helen Kurnack
24. FUNERAL DIRECTOR Chevy Chase ADDRESS 5101 - Wis ave Washington DC

25693

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 22 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09407

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA	LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
	STREET ADDRESS (If rural, give location) 10421 Lorrain Ave

3. NAME OF DECEASED (Type or Print)	(First) Morris	(Middle) E	(Last) Selby	4. DATE OF DEATH	(Month) Sept (Day) 26 (Year) 1950
5. SEX M	6. COLOR OR RACE W	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) Married	8. DATE OF BIRTH 6-10-1874	9. AGE last birthday 76 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm Mgr.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME John Q Selby		14. MOTHER'S MAIDEN NAME Rachel Harvey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS Wife Same as deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Thrombosis	48 hours.
177X Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Prostatic Carcinoma.	
51b	(c) Arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to Sept, 1950, that I last saw the deceased alive on Sept 25, 1950, and that death occurred at 7:35 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George Sharpe	M.D.	6900 Wisconsin Ave Chevy Chase 15 Maryland	Sept 26 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE 9-29-50	NAME OF CEMETERY OR CREMATORY Providence Cemetery	LOCATION (City, town, or county) (State) Howard Glen Elg, Md.
DATE REC'D BY LOCAL REG. Sept. 26, 50	REGISTRAR'S SIGNATURE Helen Kurvack	24. FUNERAL DIRECTOR F. C. Higinbotham	ADDRESS Elliott City Md

000 VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 30 1960
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09408

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH · COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: OLNEY
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural, give location): Cedar Lane

3. NAME OF DECEASED (Type or Print): (First) Josephine (Middle) (Last) Sewell

4. DATE OF DEATH: (Month) 9 (Day) 25 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 4/8/1918

9. AGE last birthday: 32 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Harding

14. MOTHER'S MAIDEN NAME: Grace Diggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002X **Immediate cause** (a) Pulmonary Tuberculosis (Hemoptysis) — 18 mos

13b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour):

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/23/50, 19..., to 9/25/50, 19..., that I last saw the deceased alive on 9/25/50, 19..., and that death occurred at 8:15 p.m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) ADDRESS: Sandy Spring — DATE SIGNED: 9/27/50

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE THEREOF: 9/28/50 — NAME OF CEMETERY OR CREMATORY: Forest Oak — LOCATION (City, town, or county) (State): Rockville, Md

DATE REC'D BY LOCAL REG. 9-28-50 — REGISTRAR'S SIGNATURE: Gertrude B. Fawler — 24. FUNERAL DIRECTOR — ADDRESS: Robert L. Snowden, Rockville, Md

M

The correct age

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. is especially important.

T

VS. A15

RECEIVED
SEP 30 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09409

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Dist. of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 3000 Connecticutt Ave., NW ✓

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Alford (Last) SINCLAIR

4. DATE OF DEATH: (Month) (Day) (Year) September 12, 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 26, 1865

9. AGE last birthday: 85 yrs. If under 1 year: Months 06 Days 16 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Broker

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Quebec, Canada

12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME: Peter SINCLAIR

14. MOTHER'S MAIDEN NAME: Carolyn FERGUSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - -

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS: Son: George A. SINCLAIR

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Arteriosclerotic Heart Disease

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

934 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

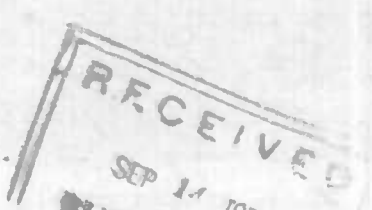
22. I hereby certify that I attended the deceased from Sept. 1, 1950, to Sept. 12 1950, that I last saw the deceased alive on Sept. 12, 1950, and that death occurred at 7:49 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) A. E. MARLAND, LTJG, MC, USN — ADDRESS U.S. NAVAL HOSPITAL, — DATE SIGNED September 12, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Cremation | DATE THEREOF: Sept. 14, 1950 | NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory | LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG.: Sept. 12, 1950 | REGISTRAR'S SIGNATURE: Edwd. Whittington

24. FUNERAL DIRECTOR ADDRESS: S. H. HINES, 2901 14th St., NW, Washington, D.C. J.L.R. 27480


RECEIVED
SEP 14 1950

09410

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22 3-

1. PLACE OF DEATH COUNTY Montgomery 401 Philadelphia Ave MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park Md / LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 401 Philadelphia Ave	STREET ADDRESS (If rural, give location) 401 Philadelphia Ave.

3. NAME OF DECEASED (Type or Print) (First) BERTHA	(Middle) F	(Last) SMITH	4. DATE OF DEATH (Month) 9	(Day) 26	(Year) 1950
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH April 19 1862	9. AGE last birthday 88 yrs.	If under 1 year Months / Days / If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Tenn	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Thomas James Montague		14. MOTHER'S MAIDEN NAME Priscilla Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Grace M Smith			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) myocarditis - with Acute Failure	12 hrs.
422.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senile Arteriosclerosis	12-15 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 Sept., 1950, to 26 Sept., 1950, that I last saw the deceased alive on 26 Sept., 1950, and that death occurred at 2 30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
G B Quellen	M.D.	112 Willow Ave Takoma Park, Md	9-26-50.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE 9/28/50	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) Fr. George Co.	(State) Md.
DATE REC'D BY LOCAL REG. 9/26/50	REGISTRAR'S SIGNATURE J. Wilson Dodd	24. FUNERAL DIRECTOR The S H Hines Co.	ADDRESS 290114 Pa. Washington, D.C. N.W.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 28 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09411

223

Reg. Dist. No. 212

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 9 1/4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium and Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Comus
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mr. (Middle) Joseph Roger (Last) SPATES

4. DATE OF DEATH (Month) 9- (Day) 1 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH 11-7-81

9. AGE last birthday 68 yrs. If under 1 year Months Days; If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lawyer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poolesville, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Spates Richard

14. MOTHER'S MAIDEN NAME Karn, Clara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Hospital Admittance Sheet (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Congestive Cardiac Failure	Demand
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Occlusion (Confirmed EKG.)	One mo.
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 23, 1950, to Sept 1, 1950, that I last saw the deceased alive on Aug 31, 1950, and that death occurred at 5:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Robert A Hare M.D. Takoma Park, Md. 9/1/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 9/4/50

NAME OF CEMETERY OR CREMATORY Monocacy

LOCATION (City, town, or county) (State) Beallsville Md.

DATE REC'D BY LOCAL REG. 9/2/50

REGISTRAR'S SIGNATURE Mrs. C. C. Hilton By Mrs. C.C.H.

24. FUNERAL DIRECTOR ADDRESS Chas. B. Hilton Barnesville Md.

25693

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 11 1950
BUREAU V. S

09412

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (In this place) aprx. 1 hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D. C.
STREET ADDRESS (If rural, give location) 409 - 4th Street, N. W.

3. NAME OF DECEASED (Type or Print) (First) Donald (Middle) J. (Last) Stambaugh
4. DATE OF DEATH (Month) Sept (Day) 2 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 2/17/29
9. AGE last birthday 21 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b. KIND OF BUSINESS OR INDUSTRY The Hecht Company
11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry J. Stambaugh
14. MOTHER'S MAIDEN NAME Hilda Schutrumpf
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Hilda Stambaugh, mother, 3711 Albemarle St. N. W., Washington, D.C.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

981X Immediate cause (a) Abdominal hemorrhage due — 1½ hrs

166 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) to bullet wound in abdomen

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Silver Spring (CITY OR TOWN) (COUNTY) (STATE) Silver Spring Montg. Md
TIME OF INJURY (Month) (Day) (Year) (Hour) 9 - 2 - 50 - 4:30 A.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 9-2-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 5/50
NAME OF CEMETERY OR CREMATORY Ft Lincoln Cem
LOCATION (City, town, or county) Prince Geo Cty (State) Md

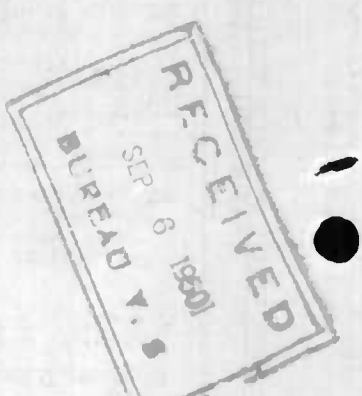
DATE REC'D BY LOCAL REG. 9/2/50
REGISTRAR'S SIGNATURE Frances Potter
24. FUNERAL DIRECTOR The S. H. Hines Co ADDRESS 2901 14th N W

26663

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A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SEP 6 1901
BUREAU Y. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09413

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dickerson
STREET ADDRESS (If rural, give location) R.F.D # 2

3. NAME OF DECEASED (Type or Print): (First) Edith (Middle) (Last) Stevens

4. DATE OF DEATH: (Month) Sept (Day) 2 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Jan 3 1901

9. AGE last birthday: 49 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Phila. Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas C Person

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hosp record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

819.5 **Immediate cause** (a) Thoracic hemorrhage due to — 2 hrs

170C **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) crushed chest.

(c) fracture left femur. numerous lacerations

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY highway

(CITY OR TOWN) Poolesville (COUNTY) Monty (STATE) Md

TIME (Month) (Day) (Year) (Hour) OF INJURY Sept 2 - 50 9: Am.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? auto accident - Collision with fixed object

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank J. Bouchart M.D. Gaithersburg Md 9-2-50

23. BURIAL, CREMATION, REMOVAL (Specify) removal

DATE THEREOF 9-2-50

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State) D.C.

DATE REC'D BY LOCAL REG. 9-2-50

REGISTRAR'S SIGNATURE Helen Kurrmeyer

24. FUNERAL DIRECTOR W. Ernest Jarvis Co. ADDRESS 1432 - Yan St N.W.

52086

RECEIVED
SEP 15 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09414

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA
LENGTH OF STAY (in this place) 12 hrs 10 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garrett Park
STREET ADDRESS (If rural, give location) 19 Keswick St.

3. NAME OF DECEASED (Type or Print) (First) Arnold (Middle) Joseph (Last) Stewart
4. DATE OF DEATH (Month) 9 (Day) 29 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 24 1871
9. AGE last birthday 78 yrs. If under 1 year: Months 11, Days 5; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't. (Retired)
10b. KIND OF BUSINESS OR INDUSTRY Engineer
11. BIRTHPLACE (State or foreign country) Maryland (Cecil Co)
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Whan Frenando Stewart
14. MOTHER'S MAIDEN NAME Sarah Perry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs Hettie Sanxay Harrison

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage Acute	1 day
331 X Antecedent cause(s)	(b) Arteriosclerosis Generalized	Yrs.
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/28/50, 19....., to 5/29/50, 19....., that I last saw the deceased alive on 9/29/50, 19....., and that death occurred at 12:10 A.m., from the causes and on the date stated above.

SIGNATURE Samuel Allen MD (Degree or title) ADDRESS Kensington Md DATE SIGNED 9/29/50

23. BURIAL, CREMATION REMOVAL (Specify)
DATE Sept. 29/50
NAME OF CEMETERY OR CREMATORY Forest Hills Cemetery
LOCATION (City, town, or county) (State) Delaware

DATE REC'D BY LOCAL REG. Sept. 29/50
REGISTRAR'S SIGNATURE Helen Kurvack
24. FUNERAL DIRECTOR The S. H. Hines Co. ADDRESS 2901-14th St. N.W. 35698 Washington 9 D.C.

RECEIVED
OCT 13 1980
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09415

CERTIFICATE OF DEATH

Reg. Dist. No. 21 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montg — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg — LENGTH OF STAY (In this place) 2Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Asbury Methodist Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Gussie (Middle) Shoemaker (Last) Stubs
4. DATE OF DEATH: (Month) 9 (Day) 29 (Year) 50

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Mar 12/1874
9. AGE last birthday: 76 yrs. If under 1 year: Months 6 Days 17 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Horse Keeper
10b. KIND OF BUSINESS OR INDUSTRY: " "
11. BIRTHPLACE (State or foreign country): Baltimore Md,
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Stubbs
14. MOTHER'S MAIDEN NAME: Mary VanSant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Records Methodist Home

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: 6½ hrs

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senile arterial disease — 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1950, to Sept. 29, 1950, that I last saw the deceased alive on Sept. 28, 1950, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
William E. Miller, M.D. 7-Brookside, Gaithersburg, Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 10/2/50
NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
LOCATION (City, town, or county) (State): Baltimore Md,

DATE REC'D BY LOCAL REG.: Sept. 29-50
REGISTRAR'S SIGNATURE: Edmund L. Cooke
24. FUNERAL DIRECTOR ADDRESS: Ernest C. Gartner, Gaithersburg, Md.

52086

RECEIVED
OCT 4 1980
BUREAU V. B

09416

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural, give location) 3405 Lincoln St.

3. NAME OF DECEASED (Type or Print) (First) STANLEY (Middle) (NMI) (Last) THOMAS

4. DATE OF DEATH (Month) Sept. (Day) 5, (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 17May1880
9. AGE last birthday 70 yrs. If under 1 year Months 3 Days 18 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Auto Dealer
10b. KIND OF BUSINESS OR INDUSTRY Self Employed
11. BIRTHPLACE (State or foreign country) Bristol, Tenn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Theopalis Thomas
14. MOTHER'S MAIDEN NAME Celesti Stanley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 442-03-4722
17. INFORMANT AND ADDRESS 9406 Kensington Pkwy Helen Thompson-Chevy Chase, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Acute coronary occlusion with infarction	One hour
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis. Coronary insufficiency symptoms past 2 weeks	2 wks +
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept 2, 1950, to Sept 5, 1950, that I last saw the deceased alive on Sept 2, 1950, and that death occurred at 5 20 p.m., from the causes and on the date stated above.

SIGNATURE Stewart Clapp (Degree or title) M.D. ADDRESS 3921 Ingomar St Wash. D.C. DATE SIGNED 9.6.50

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE THEREOF 7 Sept. 1950
NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
LOCATION (City, town, or county) (State) Prince George Co. Md.

DATE REC'D BY LOCAL REG. 9-7-50
REGISTRAR'S SIGNATURE Helen Kurvack
24. FUNERAL DIRECTOR Robert H. Humphrey ADDRESS Bethesda, Md.

15669

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 11 1950
BUREAU V. S

ITEM 22: Film C 128 10-20-50 (missing inf)

STATE OF MARYLAND—CERTIFICATE OF DEATH 09417

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 24

Village or City Rockville, Maryland No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Trowbridge, Alexander B. If U. S. Veteran, specify WAR I N.Y. State Home Guard

(a) Residence: No. 320 Sylvan Blvd. Winter Park, St., Ward
(Usual place of abode) Fla. If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Gertrude Sherman Trowbridge

6. DATE OF BIRTH (month, day, and yaar) Sept. 3, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72		24	

OCCUPATION

8. Trada, profassion, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. Architect

9. Industry or business in which work wes dona, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked et this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Detroit, Michigan
(Stata or country)

FATHER

13. NAME Stephen Trowbridge

14. BIRTHPLACE (city or town) Detroit, Michigan
(State or country)

MOTHER

15. MAIDEN NAME Julia Buel

16. BIRTHPLACE (city or town) Detroit, Michigan
(State or country)

17. INFORMANT Hospital records
(Address) Rockville, Md.

18. BURIAL, CREMATION, OR REMOVAL Cremation
Place Cedar Hill Crematory, Suitland, Md. Data Sept. 28, 1950

19. UNDERTAKER Joseph Gawler's Sons
(Address) 1756 Pa. Ave., nw D.C.

20. FILED 9/28, 1950 Frances Potter
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH September 27, 1950
(Month) (Day) (Yaar)

22. I HEREBY CERTIFY, That I attandad dacaasad from August 1, 1950, to Sept. 27, 1950

I last saw h.im alive on Sept. 26, 1950; deeth is said to hava occurrad on the data statad above, at 9 A. m.

The PRINCIPAL CAUSE OF DEATH and related ceuses of importence wara as follows:

	Date of onset
(Principal cause of death or autopsy) Arteriosclerosis, senility, ascites due to possible abdominal malignancy.	
Findings of autopsy:	
Other Contributory Causes of importance:	
(a) Hydatic cysts of liver.	
(b) Coronary arteriosclerosis - insufficiency	
(c) Senility (old infarcts)	

(10-19-50 akc)

Name of operation Data of

What tast confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to axternal causas (VIOLENCE) fill in also tha following: (1991)

Accident, suicide, or homicide? Date of Injury

Whera did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disaasa or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Travis Kyale M. D.

(Address) Chestnut Lodge

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Farber VH043

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Evidence for addition in
#22 shown on:

FILM No. G 128 OCT 20 1950

RECEIVED SEP 30 1950 BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

09418

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (Rural)
LENGTH OF STAY (in this place): 31 das
HOSPITAL OR INSTITUTION OR STREET ADDRESS: USNH, Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Montgomery — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural, give location): Travilah Rd., Rt. # 1

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Travis (Last) WADDELL

4. DATE OF DEATH: (Month) Sept (Day) 23 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12-16-21

9. AGE last birthday: 28 yrs. — If under 1 year: Months 9, Days 7 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Alanta, Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Sam Mack WADDELL

14. MOTHER'S MAIDEN NAME: Sarah Louise SINGLETON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: - - - - - - -

17. INFORMANT AND ADDRESS: Wife: Geraldine Waddell Same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acquisitai Pneumonia	12 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Glioma of Mid Brain	3 mo.
	(c)	

193X
54b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9/19/50

19b. MAJOR FINDINGS OF OPERATION: Glioma of Mid Brain

20. AUTOPSY? Yes XXX No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-22-50 19..... to 9-23-50 19....., that I last saw the deceased alive on 9-23-50, 19....., and that death occurred at 2:55 P.m., from the causes and on the date stated above.

SIGNATURE: J. J. Lawson, Jr. (Degree or title) LTJG MC USNR ADDRESS: USNH, Bethesda, Maryland DATE SIGNED: 9-24-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept. 26, 1950
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington Virginia

DATE RECD BY LOCAL REG. 9-24-50
REGISTRAR'S SIGNATURE: Edith Whittington

24. FUNERAL DIRECTOR ADDRESS: Wastler Funeral Home 301 E. Capital Street, Washington, D. C. D.C.

60896

RECEIVED
SEP 26 1990
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09419

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 422 18th Street, N.E. √

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Wesley	WALKER	September 14, 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Dec. 4, 1908	41 yrs.	09	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	US Gov't Service	Maryland	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wilson WALKER	Emma THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
YES WW II	- - - - - - -	Wife: Mildred WALKER

18. MEDICAL CERTIFICATION — Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Right Heart Failure	4 days
754.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Patent Intraauricular Septum	Since birth
1572	(c) Congenital Cardiac Anomaly	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Aug. 11, 1950, to Sept. 14, 1950 that I last saw the deceased alive on Sept. 14, 1950 and that death occurred at 1:25 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Samuel M. Fox III LTJG MC USN	U.S. NAVAL HOSPITAL	Sept. 14, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	Sept. 16, 1950	Cedar Hill Crematory	Cedar Hill, Suitland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Sept. 14, 1950	Elsie Whittington	W.W. Chambers, 3072 M Street, NW, Washington, D.C.

2669 M.T.W.

RECEIVED
SEP 18 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09420

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase — LENGTH OF STAY (in this place) 2 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5th / E. MELROSE ST.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
STREET ADDRESS (If rural give location) 6604 Strathmore St.

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) KEANE (Last) WALSH
4. DATE OF DEATH: (Month) SEPT. (Day) 7, (Year) 1950
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): ~~Married~~ Widowed
8. DATE OF BIRTH: JAN 13, 1881
9. AGE last birthday: 69 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: THOMAS T. KEANE
14. MOTHER'S MAIDEN NAME: ELLEN DONOVAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: EDWARD K. WALSH - (SON)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

196X Immediate cause (a) Sarcoma of left hip (ileum) — 1 year

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
55 (b) —
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure — 1 mo.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1949, to 9/7, 1950, that I last saw the deceased alive on 9/6, 1950 and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE: S. W. Nealon Jr. — (Degree or title): M. D. — ADDRESS: 1746 K. N.W. Wash 6 D.C. — DATE SIGNED: 9/7/50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: 9-9-50 — NAME OF CEMETERY OR CREMATORY: Mt. Olivet — LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG.: 9-7-50 — REGISTRAR'S SIGNATURE: Helen Kurosch — 24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawler's Sons Wash, DC.

RF

VS. A15

RECEIVED
SEP 14 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

09421

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9920 Rogart Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
STREET ADDRESS (If rural, give location) 9920 Rogart Road

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) LEE LAMAR WARE

4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1950

5. SEX male MALE

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH May 7, 1905

9. AGE last birthday 45 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wine Stewart

10b. KIND OF BUSINESS OR INDUSTRY Shoreham Hotel

11. BIRTHPLACE (State or foreign country) Mississippi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lee Roy Ware

14. MOTHER'S MAIDEN NAME Mary E. Shannon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 578-07-6232

17. INFORMANT Mrs. Amelia K. Ware

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 1 day

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

932 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 5, 1950 5:30 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Emil G. Baumsfeld, M.D. (Degree or title) Sub. Dep. Med Ex. Mont Co. ADDRESS Bethesda, Md DATE SIGNED 9/5/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Sept. 8, 1950

NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.

DATE REC'D BY LOCAL REG. 9/7/50

REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR Warner E. Pumphrey, ADDRESS 8434 Ga. Ave., Silver Spring, Md.

73271

RECEIVED
SEP 11 1950
BUREAU V. S

M

Or. Name

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09422

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place) 11 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5529 Fairglen Lane	STREET ADDRESS (If rural, give location) 5529 Fairglen Lane

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARY GRACE WARNER	4. DATE OF DEATH (Month) (Day) (Year) Sept. 22 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	If under 1 year Days	If under 24 hrs. Hours	If under 24 hrs. Min.
Female	White	Married	20 July 1907	43 yrs.	2	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Freeburn		14. MOTHER'S MAIDEN NAME Mary G. Harbold	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Edw.M. Warner 5529 Fairglen Lane Bethesda, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	1 hr.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Uterus with	15 mos.
	(c) general metastases.	

174X

48b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Carcinoma of Uterus	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1949, to Sept 22, 1950, that I last saw the deceased alive on Sept 21, 1950, and that death occurred at 1:44 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Emmett S. Conner M.D. 2700 Conn. Ave D.C. 9/24/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/24/50	Washington Memorial Pk	Riggs Rd. Extended-Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-23-50	Helen Kurvack	Robert A. Pumphrey	Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

Wi. 6419
6419

RECEIVED
SEP 26 1950
BUREAU V. S

09423

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park, Md
LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, COUNTY D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 1927 Pst. S.E.

3. NAME OF DECEASED (Type or Print) (First) Clement (Middle) William (Last) Wells

4. DATE OF DEATH (Month) Sept (Day) 18 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH July 9, 1875

9. AGE last birthday 75 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Contractor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Wells

14. MOTHER'S MAIDEN NAME Eleanor Butcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS chart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
	Immediate cause	(a) Congestive Failure	1 week
433.1	Antecedent cause(s)		
95a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) auricular fibrillation	unknown
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jun 1, 1950, to Sept 18, 1950, that I last saw the deceased alive on Sept 17, 1950, and that death occurred at 6 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Henry G Hadley MD ADDRESS 1252 Cuts Ln Wash DC DATE SIGNED Sept 18 50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE Sept 21-50 NAME OF CEMETERY OR CREMATORY Oak Grove. LOCATION (City, town, or county) (State) Oak Grove Va

DATE REC'D BY LOCAL REG. 9/18/50 REGISTRAR'S SIGNATURE J. Wilson Dodd

24. FUNERAL DIRECTOR Simmons Bros ADDRESS 2007 Nichols ave SE. D.C.

15609

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
SEP 21 1950
BUREAU F. S

MARYLAND STATE DEPARTMENT OF HEALTH

09424

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) one day
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) 7 West Moreland Avenue

3. NAME OF DECEASED (Type or Print): (First) Annette (Middle) Caroline (Last) WHITE

4. DATE OF DEATH (Month) (Day) (Year): September 30, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 29, 1950

9. AGE last birthday: 00 yrs. If under 1 year: Months 00 Days 00 If under 24 hrs.: Hours 13 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Ray A. WHITE

14. MOTHER'S MAIDEN NAME: Nettie DE MERRITT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY NO. - - - - - - - - -

17. INFORMANT AND ADDRESS: Mother: Nettie WHITE

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval between onset and death: 12 hours

760.5

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity

760a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 29, 1950 to Sept. 30, 1950, that I last saw the deceased alive on Sept. 30, 1950, and that death occurred at 4:20 A m., from the causes and on the date stated above.

SIGNATURE: C. H. Gilliland (Degree or title) C. H. GILLILAND CDR (MC) USN — ADDRESS U.S. NAVAL HOSPITAL — DATE SIGNED October 1, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct. 2, 1950

NAME OF CEMETERY OR CREMATORY: Arlington National

LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Oct. 1, 1950

REGISTRAR'S SIGNATURE: Edwin Whittington

24. FUNERAL DIRECTOR ADDRESS: R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.

20-9-29-0-24-1-31-1

RECEIVED
OCT 3 1980
BUREAU V. S

09425

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery County MARYLAND — 8302 Custer Road, Bethesda
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md — LENGTH OF STAY (in this place) 2 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8302 Custer Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
STREET ADDRESS (If rural, give location) 8302 Custer Rd

3. NAME OF DECEASED (Type or Print) (First) Allan (Middle) Robert (Last) Wightman
4. DATE OF DEATH (Month) Sept (Day) 9, (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH July 3, 1950
9. AGE last birthday — yrs. If under 1 year Months 2 Days 6 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert A. Wightman
14. MOTHER'S MAIDEN NAME Marian Ray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Robert A. Wightman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia, bedclothes — —

924.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

182

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home — (CITY OR TOWN) Bethesda (COUNTY) Mont. Co. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Found dead in bed. (bedclothes)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Emil G. Gauenfeld, M.D. (Degree or title) Sub. Dep. Med. Exam. ADDRESS Bethesda, Md DATE SIGNED 9/10/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 9/11/50 — NAME OF CEMETERY OR CREMATORY St Mary Cemetery — LOCATION (City, town, or county) Rockville, Maryland (State)

DATE REC'D BY LOCAL REG. 9-11-50 — REGISTRAR'S SIGNATURE Helen Kurvach — 24. FUNERAL DIRECTOR Robert A. Lumphrey ADDRESS 7557 Wisconsin Ave Bethesda Maryland

2-0-7-03-0-28-3-36-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 15 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09426

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase; LENGTH OF STAY (In this place) 10 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Chevy Chase Country Club

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Mont; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase; STREET ADDRESS (If rural, give location) Chevy Chase Country Club

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Neva	Lawson	Wilcox	Sept	20	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	2-14-1878	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	—	Ohio	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Franklin H. Lawson	Anna McDougal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Franklin H. Ellis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary occlusion	Some days dead in bed
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 940a	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank J. Bosshart M.D.		Gaithersburg Md	Sept 21-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	25 Sept. 1950	Rock Creek	Washington, D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-21-50	Ellen Russell	Robert A. Humphrey	Bethesda, Md.

RECEIVED
SEP 28 1960
BUREAU T. S.

09427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Poolesville | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Poolesville, Md
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) M. (Last) Williams
4. DATE OF DEATH (Month) Sept. (Day) 15, (Year) 1950

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug 25-1867
9. AGE last birthday 83 yrs. | If under 1 year Months | Days | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY Farmer owner
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John H Williams
14. MOTHER'S MAIDEN NAME Sallie White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs G. R. Gray

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 1) Respiratory Arrest Secondary to Cerebral vascular Accident (thrombosis with infant Left motor area) → 6 days

Antecedent cause(s) (b) Generalized arteriosclerosis 15 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertensive Cardiovascular disease

443X
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to 15 Sept, 1950, that I last saw the deceased alive on 15 Sept, 1950, and that death occurred at 11 A.m., from the causes and on the date stated above.

SIGNATURE Gordon M Smith (Degree or title) M.D. ADDRESS Barnesville DATE SIGNED 15 Sept 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 9/17/50 | NAME OF CEMETERY OR CREMATORY Monocacy | LOCATION (City, town, or county) (State) Beallsville, Md

DATE REC'D BY LOCAL REG. Sept. 16, 1950 | REGISTRAR'S SIGNATURE Charles W. Colgin
24. FUNERAL DIRECTOR William B Hilton ADDRESS Barnesville, Md. 000VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 19 1950
BUREAU [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

09428

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (In this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8824 Ylemville Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS 1317 G St N.E (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) Linwood (Middle) Earl (Last) Willingham

4. DATE OF DEATH: (Month) Sept (Day) 14 (Year) 1950

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married | 8. DATE OF BIRTH: 9-20 '97 | 9. AGE last birthday: 52 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): motorman
10b. KIND OF BUSINESS OR INDUSTRY: street car
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward B. Willingham
14. MOTHER'S MAIDEN NAME: Anne J. Stribling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Stocton Willingham

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden death.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Frank J. Broschart M.D. | Gaithersburg Md | 9-18-50

23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Sept. 18 50 | Arlington Nat. Cem. Va

DATE REC'D BY LOCAL REG. 9/18/50 | REGISTRAR'S SIGNATURE Frances Potter | 24. FUNERAL DIRECTOR Lee Funeral Home - D.C. | ADDRESS 300 4½ St N.E 45649

RECEIVED
SEP 20 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09429

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 3 mo 17 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1315 Park Road, N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) George (Middle) (none) (Last) WINERICH

4. DATE OF DEATH: (Month) (Day) (Year) September 13, 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 9, 1900

9. AGE last birthday: 49 yrs. If under 1 year: Months 09 Days 05 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk

10b. KIND OF BUSINESS OR INDUSTRY: US Post Office

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Alec WINERICH

14. MOTHER'S MAIDEN NAME: Agnes WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES ✓ (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. - - - - -

17. INFORMANT AND ADDRESS: Wife: Elizabeth E. WINERICH

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

162X Immediate cause (a) Bronchogenic carcinoma — Interval between onset and death: 14 mos.

47c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 26, 1950, to Sept. 13, 1950, that I last saw the deceased alive on Sept. 13, 1950, and that death occurred at 8:45 P m., from the causes and on the date stated above.

SIGNATURE E. W. Wilkerson, III (Degree or title) ADDRESS DATE SIGNED

E. W. WILKERSON, III, LTJG, MCR, USNR, U.S. NAVAL HOSPITAL, Sept. 14, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 18, 1950	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 14, 1950	Edith Worthington	Chas. W. Chase Funeral Home	5101 Wisconsin Ave., NW, Washington, DC

26695

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SEP 18 1950
BUREAU V. S

09430

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS/A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park; LENGTH OF STAY (in this place) 3 2 hr.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash San + Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Howard; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Highland; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) (Un named) (Middle) (Last) Wood

4. DATE OF DEATH: (Month) Sept (Day) 17 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 9-16-50

9. AGE last birthday: yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard Francis Wood Jr.

14. MOTHER'S MAIDEN NAME: Ellen West

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Record — Wash San. + Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity

769.5 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Mother pre-eclamptic toxemia (acute)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

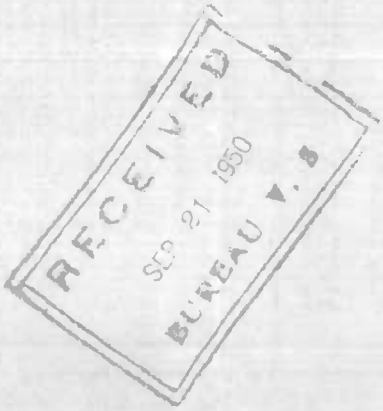
22. I hereby certify that I attended the deceased from 9-16, 1950, to 9-17, 1950, that I last saw the deceased alive on 9-17, 1950, and that death occurred at 8 06 p.m., from the causes and on the date stated above.

SIGNATURE: Ruth Hansford (Degree or title: MD) ADDRESS: 904 Ellsworth Dr Silver Spring DATE SIGNED: 9-17-50

23. BURIAL, CREMATION REMOVAL (Specify): Cremation; DATE: 9-20-50; NAME OF CEMETERY OR CREMATORY: Washington Sanitarium + Hosp.; LOCATION (City, town, or county): Takoma Park (State): Md

DATE REC'D BY LOCAL REG.: 9/20/50; REGISTRAR'S SIGNATURE: J. Hilton Dodd; 24. FUNERAL DIRECTOR: Hartwig Tak Park Md; ADDRESS

Written 2 signatures received from book parents - to Hyatt - Record Librarian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SEP 21 1950
BUREAU V. S

09431

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

216

Reg. Dist. No. ~~240~~

M

The correct age is especially important. Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians:

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Germantown
LENGTH OF STAY (in this place): 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Germantown
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Lula (Middle) E. (Last) Worthington

4. DATE OF DEATH: (Month) Sept. (Day) 2, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 10, 1875

9. AGE last birthday: 75 yrs. If under 1 year: Months 0, Days 22; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Texas.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Emma Bledsoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. George T. Walker, Route #1 Warrenton, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Influenza — Interval between onset and death: 4 days

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

481 X
260 X
61

(b) Diabetes

(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to Sept 1, 1950, that I last saw the deceased alive on Sept 1, 1950, and that death occurred at 2:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dr. Joseph P. Kennick — 7442 Wisconsin Ave, Bethesda, Md — 9/2/50

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation
DATE: 9-2-50
NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
LOCATION (City, town, or county) (State): Prince George Co., Md.

DATE REC'D BY LOCAL REG.: 9-3-50
REGISTRAR'S SIGNATURE: Helen Kennick

24. FUNERAL DIRECTOR ADDRESS: Robert A. Tumphrey - Bethesda, Md.

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BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09432

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 1 mo 21 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Quantico
STREET ADDRESS (If rural, give location) PO Box 242 ✓

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) William (Last) WRIGHT
4. DATE OF DEATH (Month) (Day) (Year): September 15, 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 6, 1883
9. AGE last birthday: 66 yrs. If under 1 year: Months 11 Days 10 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Enlisted Man
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Marines
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Frank WRIGHT
14. MOTHER'S MAIDEN NAME: Sara MC LEAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY No. - - - - - -
17. INFORMANT AND ADDRESS: Wife: Ruth WRIGHT

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hemoptosis and bronchial occlusion	2 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Metastatic carcinoma to liver hilar lymph nodes and skeleton	6 months
	(c) primary site undetermined	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Asthma

19a. DATE OF OPERATION: Jan 1950
19b. MAJOR FINDINGS OF OPERATION: Gastroenterostomy for peptic ulcer - pylonic
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 25, 1950, to Sept. 15, 1950, that I last saw the deceased alive on Sept. 15, 1950 and that death occurred at 4:12 P m., from the causes and on the date stated above.

SIGNATURE: Samuel M. Fox LTJG MC USN (Degree or title) ADDRESS: U.S. NAVAL HOSPITAL DATE SIGNED: Sept. 16, 1950

S. M. FOX, III, LTJG, MC, USN

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept. 19, 1950
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Sept. 16, 1950
REGISTRAR'S SIGNATURE: Edith Whittington
24. FUNERAL DIRECTOR ADDRESS: Hysong Funeral Home, 1300 N St., NW, Washington, D.C.

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SEP 19 1950
BUREAU

09433

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/2

M

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

I

T

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) L. (Last) WRIGHT

4. DATE OF DEATH: (Month) 9 (Day) 11 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 9-1884

9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Girard Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas McKee

14. MOTHER'S MAIDEN NAME: Emma Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: John L. Wright

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hydrostatic pneumonia	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Left hemiplegia	5 months
420.0 9320	(c) Arteriosclerotic heart disease	15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 Jan., 1950, to Sept 11, 1950, that I last saw the deceased alive on Sept 9, 1950, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

SIGNATURE: John G. Fawcett — (Degree or title) M.D. — ADDRESS: Boyds, Md. — DATE SIGNED: 11 Sept. 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9/14/50 — NAME OF CEMETERY OR CREMATORY: Monocacy — LOCATION (City, town, or county) (State): Beallsville Md.

DATE REC'D BY LOCAL REG. 9/13/50 — REGISTRAR'S SIGNATURE: Charles W. Elgin

24. FUNERAL DIRECTOR: Wm. B. Hilton — ADDRESS: Barnesville Md.

RECEIVED
SEP 15 1950
BUREAU V. S

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09434

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery Co. Gen. Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) Route 2.

3. NAME OF DECEASED (Type or Print) (First) Christian (Middle) MARTIN (Last) Young

4. DATE OF DEATH (Month) Sept (Day) 3 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Dec 13, 1860
9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME Christian J Young
14. MOTHER'S MAIDEN NAME Catherine Pepino

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Vertrees Young - Bogalusa LA.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute renal failure	4 days
	(c) Hypertensive Cardiovascular Disease	20 yrs

443X
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1949, to 9/3, 1950, that I last saw the deceased alive on 9/2, 1950, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

SIGNATURE C. H. Pigon (Degree or title) MD ADDRESS Sandy Spring Md DATE SIGNED 9/3/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial & Removal
DATE THEREOF Sept 5, 1950
NAME OF CEMETERY OR CREMATORY Druid Ridge
LOCATION (City, town, or county) Baltimore Md (State)

DATE REC'D BY LOCAL REG. 9-3-50
REGISTRAR'S SIGNATURE Gertrude B Fowler
24. FUNERAL DIRECTOR Warner E Pumphrey ADDRESS Silver Spring Md

V0894

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MARYLAND STATE DEPARTMENT OF HEALTH

09435

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Colesville (rural)
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Joliffe Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clarksville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Covington (Middle) B. (Last) Zepp

4. DATE OF DEATH: (Month) 9 (Day) 2 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 6-24-1870

9. AGE last birthday: 80 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer (formerly)

11. BIRTHPLACE (State or foreign country): Clarksville, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: C.B.Zepp

14. MOTHER'S MAIDEN NAME: Carolyn Wall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs.Lulu Zepp, Clarksville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia — 3 weeks

4467 / 131a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) nephrosclerosis — 5 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. benign prostatic hypertrophy — 10 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/22, 1946, to 9/2, 1950, that I last saw the deceased alive on 9/2, 1950, and that death occurred at 8 45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Charles S. Worthington M.D. Clarksville Md 9/4/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 9-6-50 — NAME OF CEMETERY OR CREMATORY: Linthicum Chapel — LOCATION (City, town, or county) (State): Clarksville, Md

DATE REC'D BY LOCAL REG. 9/5/50 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR ADDRESS: F.C.Higinbothom, Ellicott City, Md.

JT

OOOVV

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09436

Reg. Dist. No. 223

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 523 Maple Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) 523 Maple Avenue

3. NAME OF DECEASED (Type or Print) (First) GERTRUDE (Middle) O. (Last) ZUMBRUM
4. DATE OF DEATH (Month) Sept. (Day) 5, (Year) 1950

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH March 17, 1893
9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) York Co., Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Granville T. Myers
14. MOTHER'S MAIDEN NAME Sarah Sterner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Harry W. Zumbrum, husband

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

9757 Immediate cause (a) Asphyxia - drowning — INTERVAL BETWEEN ONSET AND DEATH 1 hour

164 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lysol poisoning + strangulation (rope)

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home (CITY OR TOWN) Takoma Park, (COUNTY) Montgomery, (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 5, 1950 2 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE Emil G. Bauersfeld, M.D. (Degree or title) Sub. deputy med. Ex. Mont. Co. ADDRESS Bethesda, Md. DATE SIGNED 9/5/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 8, 1950
NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery
LOCATION (City, town, or county) Hanover, YorkCo., Pa. (State)

DATE REC'D BY LOCAL REG. 9/5/50
REGISTRAR'S SIGNATURE J. Wilson Dodd
24. FUNERAL DIRECTOR Warner E. Pumphrey, ADDRESS 8434 Ga. Ave., Silver Spring, Md.

RECEIVED
SEP 8 1950
BUREAU OF S